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December, 1878.

THE

SAINT LOUIS

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JOURNAL.

THOS. F. RUMBOLD, M. D.,

EDITOR AND PROPRIETOR.

HIRAM CHRISTOPHER, M. D.,

ASSOCIATE EDITOR.

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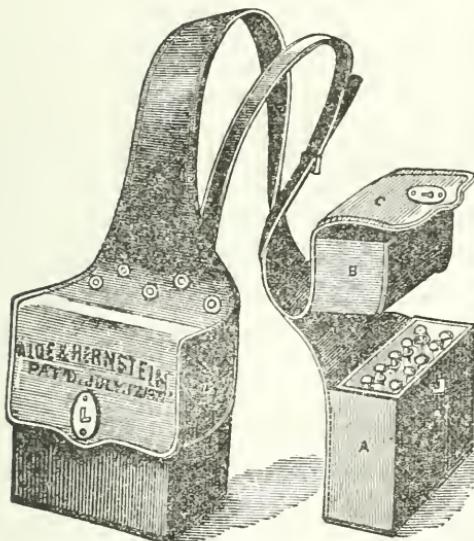
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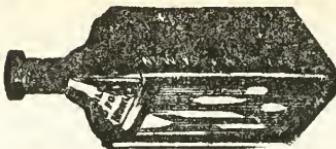
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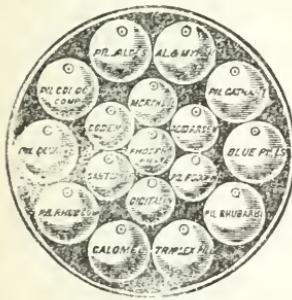
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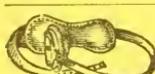
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In support of our claims we invite the attention of the profession to the following points, viz.:

FIRST: In the manufacture of MALTINE the evaporation necessary to reduce it to its great density is conducted in *vacuo*, at a temperature ranging from 100° to 120° Fahr.; while most manufacturers of Extract of Malt resort to "open pan" or low pressure steam boiling, by neither of which processes can the extract be so produced as to preserve the Diastase, Phosphates and Albuminoids on which its remedial value so greatly depends, and the product is either of a dark color or of low specific gravity, possessing little virtue aside from the saccharine matter which it contains*.

SECOND: *Carbon, Hydrogen, Nitrogen, Phosphorus, Sulphur, Iron, Magnesium and Potassium* are essential elements in the food of man, and it is only in MALTINE, containing the combined properties of malted Barley, Wheat and Oats that all these principles can be found in the proper proportions; Extract of Malt made from Barley alone is wanting in some of the most important of these elements.

THIRD: *Gluten* is the most nutritious principle found in the cereals, and is the only vegetable substance which will, alone, support life for any great length of time. It is composed of three distinct nitrogenous principles, together with fatty and inorganic matters, and is analogous to animal fibrin. MALTINE contains twenty times the quantity of *Gluten* found in any Extract of Malt.

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* As a sure test for Diastase, and the Albuminoids a small quantity should be put in a test tube or small vial, largely diluted with Water, and heated to the boiling point, when the Albumen, if present, will coagulate, and appear in little flocculent particles throughout the liquid. If the extract remains clear, it is proof that it had already been coagulated by excessive heat, and removed by filtration during the process of manufacturing. Any heat which will coagulate Albumen will inevitably destroy the digestive power of Diastase.

The Nitrogenous constituents of MALTINE have a composition identical with that of the chief constituents of the Blood, and therefore contain nearly every element requisite for the reproduction of the human body.

MALTINE AND ITS COMPOUNDS

can be undoubtedly be used with greater success than any other remedy now known, in cases of general and nervous Debility, Indigestion, imperfect Nutrition and deficient Lactation ; Pulmonary affections, such as Phthisis, Coughs, Colds, Hoarseness, Irritation of the Mucous Membrane and difficult expectoration ; Cholera Infantum and wasting diseases of children and adults ; Convalescence from Fevers, and whenever it is necessary to increase the vital forces and build up the system.

WE MANUFACTURE THE FOLLOWING PREPARATIONS, THE FORMULAS AND DOSES OF WHICH ARE GIVEN IN OUR DOSE BOOKS AND ON THE LABEL ATTACHED TO EACH BOTTLE.

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This combination is specially indicated in Aæmia and Chlorosis, and in all cases of defective nutrition where Iron is deficient in the system.

MALTINE With Phosphates Iron and Quinia :

A powerful general and nutritive tonic.

MALTINE With Phos. Iron, Quinia and Strychnia :

A powerful nutritive, general and nervous tonic.

MALTINE With Pepsin and Pancreatine :

One of the most effective combinations in Dyspepsia, Cholera Infantum and all diseases resulting from imperfect nutrition. It contains three of the all-important digestive agents, Diastase being one of the constituents of the MALTINE. We believe there are few cases of Dyspepsia which will not readily yield to the medicinal properties of the above combination, while the system is invigorated by its nutritive qualities.

MALTINE With Beet and Iron :

One of the most valuable combinations in case of general Debility, where there is deficient nutrition and a deficiency of Iron in the system.

MALTINE With Alternatives :

In this preparation MALTINE is combined with the most valuable Alternatives known, such as Iodides, Bromides and Chlorides, and will fully meet the requirements of the practitioners in Syphilis, Scrofula and all depraved conditions of the blood.

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This preparation contains all the medicinal and nutritive constituents of MALTINE, less 60 per cent of the transformed starch or glucose, which renders the preparation lighter and more acceptable to some stomachs, and is recommended only in such cases.

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(*Each fluid ounce of MALTINE WINE contains 15 grains pure PEPSIN and 15 grains pure PANCREATINE.*)

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MALTO-YERBINE.

(*Each pint of the above preparation contains 13 ounces of MALTINE, 2 ounces CARRAGEEN and 1 ounce of YERBINE.*)

With the nutritive, emollient, and demulcent properties of MALTINE and CARRAGEEN, and the expectorant qualities of YERBINE, (active principle of Yerba Santa,) we offer this preparation with the fullest confidence that is the most perfect remedy yet produced in Chronic Pulmonary Affections, Irritation of the Mucous Membrane, Difficult Expectoration, Bronchitis, and ordinary Coughs and Colds.

The Dose of all preparations of MALTINE and compounds is from a dessert to a tablespoonful.

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It affords, therefore, the very best mode of administering

IRON

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Manufactured on the Sea-Shore from Fresh and Selected Livers.

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This Oil is manufactured by us on the sea-shore, with the greatest care, from fresh, healthy Livers, of the Cod only, without the aid of any chemicals, by the simplest possible process and lowest temperature by which the Oil can be separated from the cells of the Livers. It is nearly devoid of color, odor, and flavor—having a bland fish-like, and to most persons, not unpleasant taste. It is so sweet and pure that it can be retained by the stomach when other kinds fail, and patients soon become fond of it.

The secret of making good Cod Liver Oil lies in the proper application of the proper degree of heat; too much or too little will seriously injure the quality. Great attention to cleanliness is absolutely necessary to produce sweet Cod Liver Oil. The rancid Oil found in the market is the make of manufacturers who are careless about these matters.

Prof. Parker, of New York, says: "I have tried almost every other manufacturer's Oil, and give yours the decided preference."

Prof. Hays, State Assayer of Massachusetts, after a full analysis of it, says: "It is the best for foreign or domestic use."

After years of experimenting, the Medical Profession of Europe and America, who have studied the effects of different Cod Liver Oils, have unanimously decided the light straw-colored Cod Liver Oil to be far superior to any of the brown Oils.

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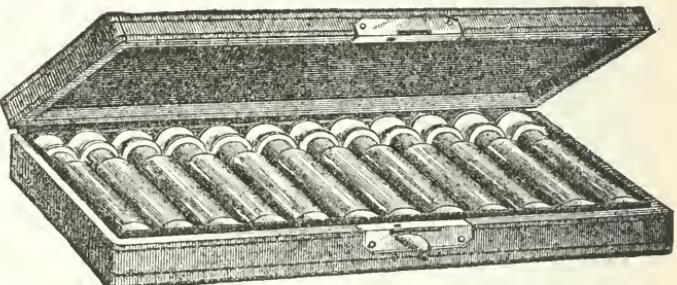
To give a better idea of the capacity of the Vials, we append the number of one-eighth grain Morphia, and one and two-grain Quinine Pills, which they will contain; the Cases Nos. 4 and 13 are the only ones which have vials large enough to admit of four or five-grain Pills.

The prices here given include the empty Vials; should they be desired filled with Pills, not procurable at druggists at home, the Pills will be charged at list prices.

No. 5.—Same style as cut, containing two rows of bottles, but cork-stoppered.

No. 8.—Same as cut, only cork-stoppered.

No. 10.—Same style as cut, containing two rows of bottles, glass-stoppered.



This Cut represents Case No. 9.

McKesson & Robbins' Vial Case No. 5. Size, 7 inches x 2½ inches x 1¼ inches; contains twenty-four half drachm Homo. Vials, secured by leather socket. This size is meant more especially for the smaller Pills. Vials contain 80 to 90 Granules each; 23 one-grain Pills, or 7 two-grain. Price, \$4.00 each.

McKesson & Robbins' Vial Case No. 8. Size, 7 inches x 2½ inches x 1 inch; contains twelve half drachm, Homo. Vials, set in leather sockets. Capacity of Vials, same as No. 5. Price, \$3.00 each.

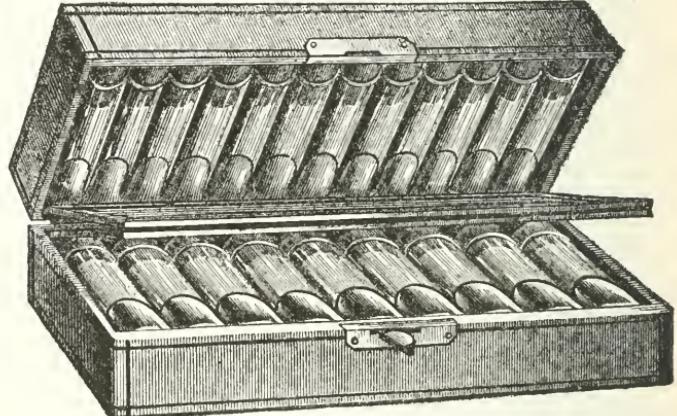
McKesson & Robbins' Vial Case No. 9. Size, 7 inches x 2 2/3 inches x 1 inch; contains twelve half drachm heavy flint glass, mushroom-stoppered, Vials; very handsome. Capacity, 75 Granules; 20 one-grain, or 7 two-grain Pills. Price, \$3.50 each.

McKesson & Robbins' Vial Case No. 10. Size, 7 inches x 2½ inches x 1¼ inches; contains twenty-four half-drachm heavy, flint glass, mushroom-stoppered, Vials, secured by leather socket. Capacity of Vials, same as No. 9. Price, \$5.00 each.

No. 11.—Same as upper half of cut.

No. 12.—Same style as cut, with the lower half of cut same as upper.

No. 13.—Same as No. 12, only the bottles are shorter.



This Cut represents Case No. 4.

McKesson & Robbins' Vial Case No. 4. Size, 6¾ inches long; 3½ inches wide; 1¾ inches thick; contains twenty-one Vials, secured by polished brass spring shields. The Vials are two sizes; nine with a capacity of 175 Granules; 40 one-grain; 21 two-grain, or 7 five-grain Pills, and twelve Vials holding 85 Granules; 22 one-grain; 9 two-grain, or 5 five-grain Pills. Very convenient for the larger size Pills. Price, \$5.00 each.

McKesson & Robbins' Vial Case No. 11. Size, 6¾ inches x 3½ inches x 1 inch; contains twelve long-case Vials, secured by neat, polished brass, spring shields. Capacity, 85 Granules; 22 one-grain, or 9 two-grain Pills. Price, \$3.50 each.

McKesson & Robbins' Vial Case No. 12. Size, 6¾ inches x 3½ inches x 1¾ inches; contains twenty-four long case Vials, similar in style to No. 11. Price, \$5.00 each.

McKesson & Robbins' Vial Case No. 13. Size, 7 inches x 2½ inches x 1¾ inches; contains twenty-four short Vials, secured by neat, polished brass, spring shields. Desirable where a narrow case is needed. Capacity 75 Granules; 17 one-grain; 6 two-grain, or 4 five-grain Pills. Price, \$4.75 each.

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Original Contributions.

ARTICLE XXIV.

OPERATIVE TREATMENT OF INTERNAL HEMORRHOIDS. By A. P.
LANKFORD, M. D., of St. Louis.

One of the most important ends attained by our periodical literature is the comparison of the results of various methods of practice. But for the facilities thus afforded, progress in this direction would be slow. But for this, many methods hallowed by time, sanctioned by great names, good in themselves and in their day, but existing only in the annals of our art, would still be the rule. The practical importance, however, of our question, makes a formal introductory apology unnecessary; *The Operative Treatment of Internal Hemorrhoids*; not that form of the affection usually designated as “external piles.” When these tumors are situated about the verge of the anus and external to the sphincter the operation for their removal is so simple, safe and effectual, that there can be no question about it.

With all other forms, (internal hemorrhoids) the case is quite the reverse. We are far from being agreed as to the best method of dealing with them. The problem being the thorough re-

moval of these annoying and painful vascular bodies by the quickest, safest and least painful means; I wish to call attention to two proceedings now generally recognized as well established: 1st, operation by the ligature, in general use; 2d, by the clamp and cautery (Smith's); the advocates of which are to be found chiefly amongst our brethren upon the other side of the water, believing its solution is accomplished by one of these procedures. I leave out of the question the injection of such agents as carbolic acid (which may be comparatively safe and effective in certain cases), the salts of iron, the insertion of the heated probe, etc., as also the application of nitric acid, and by the ecraseur, believing their application limited, and that a discussion of their respective real or fancied merits in this connection, is of doubtful or at least secondary importance. It is between the two methods first named that I would attempt to decide. In the first the tumor being exposed is transfixed through the base by a needle armed with a double cord. Each one is then firmly tied separately so as to strangulate the entire mass. If more than one exists they are in succession treated in the same manner and all returned inside the sphincter. Within from six to ten days they are separated as sloughs and come away with the ligatures. Some prefer to dissect up the mucous covering of the pile first and then ligate. The ligatured mass is sometimes put away near the point of ligation. Thus it will be seen that the tying of the pile is only the beginning of trouble. A mass of dying and dead tissue (more often several masses) is left in the rectum in contact for several days with highly sensitive and organized tissues—an absorbing surface. What wonder then that some of the patients so treated perish from sepsis (pyæmia?) others from tetanus, and others from "effusion on the brain," that all are certain to suffer acutely for several days, that convalescence is tedious and painful? To the six or ten days required for the separation of the ligatures and sloughs may be added from one to four weeks of irritation more or less severe according to the number and size of the piles removed, before the patient can be called "well." He must be confined to bed and kept under the influence of anodynes for from five days to two weeks after the operation. Should ischio-rectal abscess or chronic ulceration of the rectum result, not only will the time be prolonged, but a repetition of operative procedures become necessary.

In the second method the tumor being brought well into view, the clamp is applied to the base so as to include the entire mass, when the blades are made to grasp it firmly by a few turns of the screw. The pile is then cut away near the surface of the clamp and the stump cauterized with the hot iron or nitric acid. The iron is to be preferred in all cases. The grasp of the clamp should then be relaxed a little by reversing the screw, when any vessel not sealed up will emit blood, and the cautery can be re-applied. If well done at first this will scarcely ever be necessary. Each tumor must be removed separately. The surface is then wiped carefully with a bit of lint wet in a carbolized solution. When the operation is finished and the protruded portion returned a suppository of the aquaeous extract of opium may be introduced or morphia given endermically. Ordinarily the patient is kept quiet in bed for from two to four days, when the bowels may be moved by a gentle laxative.

The following brief notes of a few cases in which the piles were removed by this operation will give a fair and true idea of the general results in my practice, and as well as I can ascertain they are corroborated by the extended experience of others.

CASE I.—R. M—, aged 49 years. Had suffered for many years and had local and general medical treatment prescribed by different physicians in Cincinnati, his former home; was operated upon May 10th, 1870, and had five large internal piles removed with clamp and cautery; bowels moved without medicine on the third day after the operation and he walked about his premises the same day; the next day he went to his store and remained two or three hours. The only treatment enjoined was now and then a mild laxative and enemas to prevent accumulations in the rectum, for about two weeks. He had remained quite free from any return of his malady up to August, 1876.

CASE II.—Patrick O. K—, aged 58. Operated upon in December, 1871. Three internal piles were removed. He had suffered from repeated hemorrhage; the mass protruded with almost every stool, and he was quite feeble at the time of the operation. The bowels were moved on the fourth day with castor oil and an enema; he got out of bed the next day, continued to improve and was discharged well on the seventeenth after the

operation, saying he felt stronger and better than he had for a year.

CASE III.—J. M—, aged 44. Operated upon on the 16th of November, 1872; seven piles were removed; there was no hemorrhage, bowels moved on the fourth day, and on the seventh day after the operation while going through the hospital, I was much astonished to meet him in a hallway carrying two buckets of water. He had at his own request been detailed as convalescent "help" by Dr. Prewitt, the Superintendent of the City Hospital, the sixth day after the operation. There was no subsequent complaint from him and he left the hospital three weeks afterward quite well.

CASE IV.—C. P—, aged 38. A gentleman of wealth and leisure, and fond of the pleasures of the table; had been treated from time to time for the past five years, but finally came to suffer so acutely and often that he concluded to try to obtain a radical cure; operated upon with the clamp and cautery July 3d, 1874; four piles the size of chestnuts were removed. A small one situated between two of those removed was allowed to remain, with the idea that it would disappear afterwards. He was kept in bed four days when his bowels were evacuated by enema. As he felt quite free from pain, only a "little soreness," as he said, he got out of bed. A man of full habit, weighing two hundred pounds until within a few months, he had been reduced to about one hundred and seventy-six, so that he was now comparatively feeble. He rapidly improved and within a little more than two weeks was unaware of the slightest pain or uneasiness in the region of the rectum. He soon regained his usual weight and remains free from any symptom of return (Nov., 1878).

CASE V.—R. Y—, aged 40. Was operated upon some years before by Dr. Hodges, of Boston, by the ligature. The disease returned two years afterward, and having lately annoyed him almost constantly, he was operated upon with the clamp and cautery, October, 1876; two large tumors were removed; he was out of bed on the sixth day and out of doors on the thirteenth day. Three weeks after the operation he had resumed business. (He is a traveling solicitor for a mercantile house.)

Comparing the two methods with regard to the degree of pain and annoyance after the operations, he is most decided in his preference for the latter. His first convalescence was tedious and painful, and not until after ten weeks was he able to attend to business. This is the only case in which I have used the clamp where the patient had been operated upon before by the ligature, and his testimony is striking.

Since I first adopted the clamp and cautery in 1869, I have used it in operating upon forty-two cases in hospital and private practice, and I can truthfully state that the above cases give a fair illustration of the general results. Not a single death has occurred.

I admit that the danger of a fatal termination after using the ligature is very slight. Mr. Amandale has seen four deaths in two hundred operations, or one in fifty. I have never known one, but I sincerely believe that the danger after the use of the clamp and cautery is much less, very much less. But admitting the hazard to be equal, we should surely prefer that method which is attended with the least suffering to the patient, and followed by the quickest recovery. My experience so far is decidedly in favor of the clamp and cautery.

Believing that the injection of an internal "pile" tumor with carbolic acid or other agent, *may* be followed by thrombosis, etc., I look upon all such plans with little favor. Practically I am not in a position to express an opinion of such procedures. If we operate with the clamp and cautery, with the aid of an anaesthetic, the actual pain experienced by a patient during his treatment is so slight as to be scarcely worth taking into the account, while the time occupied is less than half that consumed by the other method. Since my object has been simply to judge between the two operations above specially mentioned, little has been said about after treatment, and nothing about the preparation of the patient, medical treatment and other details.

If the evidence above given will assist in convincing practitioners that the operation usually termed Smith's, by the clamp and cautery, is the quickest, (the recovery of the patient) safest and least painful, and thus contribute to its adoption, its object will be attained.

ARTICLE XXV.

REPORT OF CERTAIN MEDICO-LEGAL CASES. By THAD. M. STEVENS, M. D., of Indianapolis, Ind.

[The following cases are reported and attention called to certain points developed by them, not in the spirit of personal criticisms of any individual, but simply that the attention of physicians and those interested may be directed to the necessity of taking some steps to remedy conditions in connection with some expert testimony which all must admit to be wrong. For the last five or seven years, especially, much has been said about the evils arising from such testimony, both as regards the attorney and physician, but the most good that has been accomplished has been by sharpening the perception and controlling the egotistical daring of experts by the reports of such cases as that of Mendicott, Schaffe, Wharton, etc.]

While there are a great many points in toxicology not fully understood, there is still a great deal known upon the subject, and received by authority, that needs to be brought pointedly to the minds of not only special and general practitioners, but of experts. Professors Reese and Wormley have (outside of their published systematic treatise) done much to bring special points of interest more fully before the profession.

We propose in this paper to mention some things that have come under our own observation, thoughts that have been thrust upon us by experience.

In this city a man was accused of poisoning his wife by strychnia. We will first give a synopsis of the hypothetical case put by the attorney, and afterwards that of the testimony relevant to the points we wish to discuss. The following is the gist of the case as presented by the attorney for the State:

"Suppose that a woman about 50 years of age had suffered from neuralgia of the stomach for some time, but for several weeks had been much better. She was in the habit of taking morphine to allay the pain; she had been up all day attending to her household duties; was out at the gate at six o'clock P. M., conversing with her neighbors; between seven and eight o'clock her husband gave her, in a glass stained by tincture of iron, a powder dissolved in water; within a few minutes after she be-

came sick; her neighbors gathered in after eight o'clock and found her in a convulsion; the doctor arrived about half-past eight o'clock; she said a brownish-colored powder had been given her, that it was as bitter as quinine and made her sick, and that she had a bad spell and felt so queer, and said she would die if they let her have those spasms any more; her pulse was accelerated; her respiration was hurried; her face and lips of a livid color; her countenance indicated fear; she had lain in bed for an hour; when the doctor arrived she lay on her back; her arms were naturally extended at her side; there was a slight flexion of the fingers; in about ten or fifteen minutes another convulsion followed which was tonic in character; eyes open, pupils dilated, a wild look in the face, hands clenched, body and feet stretched out with violent cramps, head thrown back, arms drawn over chest, drawing of the corners of the mouth, body and face of a livid hue; the convulsions lasted from a half minute to two minutes, with decreased intermissions, until half past ten o'clock, when she died in a convulsion; the first evidence of approaching convulsions appeared in the fingers, arms and lower limbs, afterwards extending over the body, and then to the face and jaws, each convulsion coming on in a similar way; they were followed by relaxation and full consciousness; a dose of chloroform, about 40 drops, was given her about nine o'clock, or a little later, and sometime afterwards, not more than 60 drops more was given; she once asked to be turned over; when a convulsion were coming on she asked to be held; asked for water, and when her lips were touched with the spoon containing the water, she went into a convulsion; a slight touch, and a person walking across the room, thus slightly shaking the house, each brought on a convulsion; she perspired before her death; when dead, the body was in a relaxed condition, but soon afterwards it became stiff, and so continued for a number of days after death; before the manifestation of these systems, she had no trouble of this kind, and was suffering only from neuralgia of the stomach.

From the symptoms and facts, what, in your opinion, was the cause of her death?"

The hypothetical case put by the defense only differs slightly from this, except that "no examination of the stomach, kidneys, bladder or womb was made, or at least none was reported." The stomach, however, had been examined, and no poison found.

To the first of these hypotheses, a very well-informed chemical expert assumed "that it would cover almost the entire ground" of a case of strychnia poisoning; that at least only one symptom mentioned was out of the general rule in such cases, viz.: the interval between the paroxysms being at first from ten to fifteen minutes."

To the second hypothesis, his answer was "that death might possibly be caused from uræmic poisoning or from hysterical convulsions;" also that such convulsions might be produced by morphine, the action of morphine and strychnia often being so similar as to be mistaken one for the other, although this same witness, in the preliminary examination (before the grand jury), having been summoned by the prosecution, testified that "*there was no similarity between the effect produced by the two articles ! ! !*" Upon the point of the detection of strychnia, he said the ten-thousandth part of a grain could, and ought to be, found in any case of poisoning by strychnia, under any circumstances.

An expert of good authority made answer that, "in his opinion, it could, under the hypothesis, be nothing but a case of strychnia poisoning," that "while uræmic poisoning produced tetanic convulsions, etc., the time at which death occurred eliminated a supposition of that kind from the case, as he was not aware that death had occurred in less time than two days from uræmic trouble."

The hypothesis of the defense did not produce any change in his answer. The symptoms and circumstances of the case were alone sufficient to form his opinion, as stated, without chemical examination.

Another physician examined answered, in the main, similarly, except that he was not so positive, and instanced one point in the symptoms that, according to his judgment, differed from a usual case of tetanic convulsions, viz.: the legs being in normal condition instead of being widely separated.

A chemist, giving the distinction between symptoms of strychnia poisoning and tetanus, both idiopathic and traumatic, gave it as his opinion that the hypothetical case presented was a typical one of strychnia poisoning; also, that morphia being present, it would obscure the test for strychnia, and that, to detect with certainty, we must separate the one from the other, and that the facts narrated in the hypothetical case pointed, even without a chemical analysis, to strychnia poisoning.

An extraordinary incident in the above case was that the expert whose testimony was reported first above, asserted that the stomach having been analyzed and no strychnia found (as we shall see because of a faulty analysis), therefore no strychnia was present; still the attorney for the defense, obtaining the glass from which the potion was given, gave it to the expert mentioned, for the examination of its contents. The chemist reported to the attorney that a large amount of strychnia was obtained from such glass; and yet this knowledge was kept entirely in the background, and the jury, by the testimony of the same expert, led to believe that no strychnia had been found, either in or out of the body. It was also proven that the accused had purchased strychnia, a few days previous, of a neighboring druggist; thus, all the circumstances and all symptoms pointed to death by strychnia, and that administered by the prisoner. The only point upon which acquittal was based was the fact that strychnia was not found, and, as we have seen, this was not proof of the absence of the article. After the case was over and the accused cleared, the fact of finding strychnia in the glass by the expert whose testimony went so far to acquit was gleefully narrated by the attorney as a proof of his own shrewdness.

Whatever the privileges of an attorney may be, the expert was certainly, in this case, placed in an unenviable position.

The above synopsis of evidence and results opens up numerous points of interest to medical witnesses, upon some of which the teachings of recognized authority, although in the main plain enough, needs to be collected and systematized, for the reason that medical men or attorneys fail to obtain the gist of such teaching. We do not say that experts cannot perform their work as well as those whose authority we follow, but they each, upon different subjects, consult different authorities, who present the thoughts in different language.

When we are called upon the witness stand, we should consult and reconcile all who are indeed authorities. This is what we wish to do in the following comments, as far as we go. Nothing new from us need be expected.

The following are the points we will notice, and call attention to authorities:

1st. Can strychnia, morphia, etc., taken into the stomach always be found, after proper and diligent search, in the contents or coats of the stomach, tissue or blood? With reference

to this question, consult Taylor's "Med. Jurisprudence," edition of '75, pages 691-693; here some of the poison was obtained from the stomach, but none from the tissue. Also, same page, where none was found. Page 694, the non-detection was held as no proof of its absence. Page 556, as to extraction of morphia.

Taylor, on poisons, pages 788-789, where this subject is elaborately discussed and similar conclusions arrived at, both as regards strychnia and morphia.

"Manual of Toxicology," by Prof. Reese, page 431, (from Prof. Casper) where grs. iii were found in the stomach, but none in the tissue or blood; also in same, page 433 (failure to detect), also second case, same page, where grs. vi were taken, examined six weeks after death; none found in stomach or elsewhere.

Wormley's "Micro-Chemistry of Poisons," page 503, case of Dr. Christian, as to non-detection of opium, although it had been taken; in same page, 503, as to recovery of morphine from the tissues; page 591-592 as to the detection of strychnia in the coats of the stomach or tissues, which is considered very difficult.

Guy's "Forensic Medicine," page 549; he only combats the idea that strychnia is never to be detected in the *tissues or blood*, but says nothing as to the cases where it may not be found.

2d. In cases where strychnia, morphia, etc., are known to have been taken and not detected, how is such non-detectiveness accounted for?

The following are the causes laid down in all authorities:

1st. The nature of the poison, there being no known tests for it.

2d. Loss by vomiting, purging, etc. In most cases, however, the most violent vomiting does not dislodge the poison.

3d. Loss by absorption and elimination. In death by 5iss of landanum after six hours, no morphia or meconic acid was found. (See Christian case reported in Reese's "Toxicology," page 71). It was presumed that the non-detection was from this cause. So of cases in which strychnia was sought for when six grains were taken; death in six hours; none found by Dr. Reese.

It is very true that Woodman and Tidy, upon the authority of Dr. Rogers, say that in case of death by strychnia, and the victim dies within two or three hours, the poison should be found in the stomach, for although they admit that if death is delayed it may then be lost by elimination, they hold that the

time mentioned is not sufficient to permit loss in this manner.

The questions which will be more fully noticed in a case yet to be reported, as to what is meant by death must be taken into account in this connection, for certainly elimination from the stomach of an article in solution may go on even after *somatic* death; the capillaries and absorbents still continue to act, more rapidly in some cases than in others, according to the nature of the substance contained in the stomach, etc. The exact time when such action ceases in every case has not to our knowledge been ascertained, so we must view this testimony of Dr. Rogers in the light of such circumstances, and only conclude that in rapid somatic death (for that is what he means), the probabilities of the removal of the poison from the stomach by the process of elimination is rendered less.

4th. Decomposition of poison in blood or tissue. This is no doubt true in some, but as yet only probable as regards strychnia and morphia.

5th. Decomposition in the dead body. This is not considered probable as regards strychnia, for several months at least. Another cause not spoken of by some, but recognized by Wormley, Reese and others, and first noticed by Brieger in 1850, is the presence of certain substances, such as quinine, morphia, etc., where strychnia is sought for. It is certain that those substances will obscure, and some absolutely forbid reaction to tests upon strychnia. Morphia, in excess of strychnia, and when both are in minute quantities, will (according to those authorities) interfere with the reaction. It is true that this pre-supposes in our present state of knowledge an imperfect analysis, for the strychnia can be separated from the other articles, and should be in all cases. But suppose that by reason of a faulty analysis this should not be done, it would bear the same relation to the proof of strychnia in the stomach or tissues as do any of the causes of the failure in the detection of the poison, viz: it does not prove its absence, but leaves that question untouched. Such fact would have to be proven in other ways; thus the presence of morphia ought to be placed as another cause of the non-detection of strychnia.

The sum of the whole is that non-detection of poisons is no proof that it had not been taken, nor even that it was not then present.

Take the case of the State vs. Palmer, or the "Cook case," as it is termed. Palmer was convicted, although Dr. Taylor

failed to detect strychnia. It was held first that the stomach had been opened and contents removed, therefore no strychnia could be found. This would have been a true case of non-detection, other proof being ample as to its presence, but second, it was held that the mode of analysis was faulty, and that if a proper one had been made, strychnia might have been found; this objection was made by Dr. Letherby. If this was the case it would have been a true cause of *non-detection*, but would only make the suspicion of death by poisoning stronger than if had there been a true and proper analysis. But again morphia was known to have been administered shortly before the pills supposed to contain strychnia; we have seen that morphia would (if in excess) interfere with the tests of strychnia. This would be another cause of non-detection, and if we say the strychnia might and should have been separated from the morphia, it matters not; it, simply along with all other causes mentioned, left the indication of the presence of strychnia without the additional evidence of analysis; it was proper then in that case, as it has been in many others, that if all other proofs offered as to the administration of the drug with the intent to destroy, and as to the final cause of death should be made satisfactory to the minds of the jury, either of the coroner's or higher court, conviction should follow, notwithstanding the poison had not been found, it is true that finding it would be "confirmation strong" as to the cause of death, but it would not be certain proof even in the presence of all the other facts of the case, for not only have cases been recorded but it is a fact, any one can see at a glance, that poisons may and have been found in the body with convulsions and other symptoms very similar to those mentioned, and yet death did not result from such; for instance they might be given in medicinal doses, which fact might or might not have been known to those making the examination. In fact the analysis may not discover anything when there is something there, through some irremediable causes or by the fault of the analysis, or, on the other hand, discover something which may, without the greatest care, cause us to be misunderstood, and permit censure to fall when and where it ought not.

The facts thus obtained from an analysis are only to be viewed in the same light and bearing as others revealed throughout the whole history of the case. True, conviction may follow when

there has been no analysis, and a just acquittal where a true and proper analysis has revealed the presence of poisons.

In the "Cook case," where Palmer was accused of poisoning him, the symptoms and circumstances alone were relied upon to convict. (See Taylor on Poisons). It is true that it is seldom that these two items of testimony can be sufficient, but where the symptoms of strychnia poison have been minutely noticed from first to last, and in addition the circumstances point to a giving of some "deleterious" article, then in many cases we might be justified in regarding it as a case of strychnia poisoning. Whether criminal or not is another question according to other proof added. Certainly, however, in most cases extreme caution must be observed by experts in deciding as to the absolute cause of symptoms alone, or even in connection with suspicious circumstances, for instance, that a death was occasioned by some irritants, or where no signs of irritation exist, but the nervous system is powerfully impressed by some article, we often cannot assert positively without something more to rely upon than symptoms or circumstances, that arsenic has been the active agent.

CASE II.—Another case either illustrates the falsity of experts, or a woeful lapse of memory. In this city two men were suspected of the murder of a third; one was arrested at once. Upon trial the physician who attended the murdered man at the time of his injury, testified to his having found wounds upon the head, one necessarily fatal, two dangerous, one slight. Their positions, etc., were described from notes taken at the time. The same physician, in company with a second, made a post mortem examination of the murdered man, both signing the report. The *attending* physician testified that the skull was "fractured but not depressed," etc. His associate was not examined during that trial, but afterwards the second murderer was arrested and tried; the attorney defending summoned the physician who had *assisted* at the autopsy, and whose name was signed to the report. He asserted that he had examined the head of the deceased directly after the injury; that one serious wound and two or three slight abrasions were found; that the fatal wound was at the prominence of the parietal bone; that this had not only *fractured* the skull, but *depressed* it; in fact such a depression as would be made by the body of an ale bottle

(making an impression one and a-half or two inches in depth), with a fracture running to the base of the skull, where a clot of blood appeared. His recollection was *very* distinct, not only as to the form of the principal wound, but also that there was *no* wound at the junction of the sagittal and lambdoidal sutures. This could not be, he said, as these two sutures run *parallel* with each other!!! there was none over the mastoid process. All this he was *certain* of, and ridiculed any reports that would state such facts, but when the prosecuting attorney showed the report of the autopsy, and asked him if he did not write such, and also sign it as his report, he at first replied "yes," but it *certainly had been changed*; but when no alteration in the writing could be found, he explained the fact that he had reported a fracture, but no *depressions* of the skull, by saying that at the time he first examined him (before the autopsy) there "might have been a depression which had disappeared before the time of the autopsy!!!" Such are the shifts men are driven to in such cases. Are they objects of pity or condemnation?

As to the language of the report that "a wound was found at the junction of the sagittal and lambdoidal sutures" he had nothing to say in view of his former assertion, "that such was impossible, they being parallel!!" Whether such a complete discomfiture was the result of ignorance or some other cause, we leave the reader to judge, after saying that this was the same expert that in the first case reported (strychnia poisoning), pretended to (or did), detect the strychnia in the glass given him by the attorney, and this before his testimony (that had much to do in clearing the accused) was given!!! We feel humiliated while we write that we have such experts (?) among us.

CASE III.—Another point we wish to examine is whether a poison introduced into the stomach after somatic death, can produce like effects upon that organ to the same taken before death. At a certain trial in this city where a man was accused of poisoning his wife with arsenic in order to obtain the amount of a policy of insurance she held, the stomach and contents were analyzed, arsenic was found, but none of the adjacent viscerae were examined; a small quantity of fluid mixed with mucus appeared in the stomach and upon the mucous membrane, which in places was of a reddish hue, small ecchymosed spots were seen. Such appearances were held to be due to the action of the arsenic.

The defense entered the plea that arsenic was introduced after death by parties interested in the insurance company, they having had the jar, which was improperly sealed in their possession for several days after the post mortem examination, to the exclusion of any friend of the accused. All the experts but one testified that the appearance of the stomach as described in the hypothetical case, indicated beyond a doubt that the arsenic was administered during life; the dissenting one testified that as death was a relative term, its meaning not embracing the cessation of "vitality" in the system, the same appearance in "kind" but not in "degree" could be produced by an irritant introduced into the stomach before such "vitality" had ceased, but as to the time of the cessation of such active processes he could not state, it lasting longer in some than in others, and indeed the time not having been definitely settled so as to make a general rule as to its length. This theory was held to be visionary, for "where a man was dead he was dead, and life having ceased nothing could impress any part of the system as before death," such was the reasoning. It is of great practical importance to toxicologists and jurors that this point should be understood, and first we must separate the idea of "somatic death" from the cessation of "vital action." It may seem strange that we are called upon to bring this point to the notice of experts at this time, but nevertheless we find an amount of forgetfulness that we would not have looked for, and that with gentlemen who were generally well posted. The very important fact noted by Dr. Reese, of Philadelphia, in his work on toxicology and subsequently more fully as found in the *American Law Journal*, for February or March, 1878, as to the imbibition of poison by the organic tissues adjacent to the stomach, which, when placed in that organ after death, was touched upon in this trial, but the subject turned upon the effect of arsenic, etc., upon the coat of the stomach itself.

It is a physiological principle well established, that after the heart ceases to pulsate or the lungs to receive air, that the blood is forced through the capillaries by the same vital activity that causes it to circulate before such cessation of the central organs has taken place. This is the first step in the testimony as to the continuance of "vitality" after what we designate, in general terms "death," but experiment, however, shows that vital action—
u reater or less degree for hours, nay, days, after

such a condition has been acknowledged. Of course we throw out of the count cases of suspended animation, trance, etc. If a body is found a few hours after death with wounds upon it, it often requires great skill to ascertain whether such were inflicted before or after the first steps in systemic death had commenced. Often the solution of the question is impossible. The effusion of lymph, the show of inflammatory action, discharge of blood, puffiness of the lips of the wound, etc., are held to indicate the act before death; the absence of these that it was after, but practically we are as often at fault as otherwise, in judging as to the time.

This fact is recognized by all toxicologists as well as physiologists. Orfilla lays it down as a rule that often in twenty-four hours an irritant will produce none of its characteristic signs upon the stomach, "because the vitality of the capillaries has ceased" but experiment has not, to our knowledge, been extensive enough to establish the limit of time, although reasoning by analogy may seem to satisfy us that such suppositions are correct.

CASE IV.—Not only do mistakes, misunderstandings, the drawing of false conclusions from observed facts, etc., happen with attorneys, experts and the court, but jurors are liable to similar imperfections. While the teachings of attorneys or physicians are often to blame for this, still sometimes the false position is taken originally by the jurors. This shows most clearly how careful we should be and also how careless we often are. In a certain case an inquest was held upon the body of a man who had died after being confined to his bed during the day. The autopsy revealed the fact that both lungs were extremely diseased, the right one being completely disorganized, full of cavities and the cells impervious to air; the left one (except a very small portion of the upper lobe) being in the same condition. The physician (a man of small repute) testified that six weeks before, the patient came to him with cough, expectoration, want of respiratory murmur, etc., stating that he was taking in addition to other medicines, the contents of a certain powder, several of which he had with him. The physician, by inspection, found them to be composed of about one and one-half grains of morphine; these powders he continued to use to allay the cough and irritation, and they seemingly produced no bad effect. After an exhausting walk

upon Friday, he retired to bed until next day, when the physician was called and gave him one of the powders. It was proven that there was no mistake as to the quantity contained in each powder. He was suffering from pleuritic pains, coughs, and great exhaustion; seemed to doze but not sleep during the day, and finally died about 7 o'clock P. M., with nothing to indicate opium poisoning when the symptoms were analyzed. The stomach was given to a chemist, who found morphine. The brain was found to be in a condition that some who are not experienced would deem indicative of an inordinate amount of congestion, but, in fact, very slightly more than is found in eight-tenths of all cases of deaths from any cause.

Two physicians, who were present at the post-mortem examination, were examined. They insisted that the brain was highly congested, and, when asked if they could give a reasonable cause for such condition, both replied that it was from opium. The question remained with the jury (composed partly of physicians) how such a conclusion could be arrived at, for, if the brain was highly congested, might there not be other reasons under the circumstances to cause it? No other evidence was introduced, the case going to the jury. They decided that the individual came to his death "from natural causes," meaning, evidently, in consequence of the disorganization of both lungs.

The coroner and the physicians examined, all asserted they believed the patient to have been poisoned by morphine, and that the drug caused death, although they admitted that he could have lived but a short time longer with such a pathological condition. The fact that when he came to be treated by the physician accused of trying to destroy his life, he had been and was a user of morphine in large doses, and that, if he had not been, the first dose of one and one-half to two grains would have produced alarming, if not fatal, symptoms, was overlooked, although, when their attention was called to the fact, such a proposition was admitted as true. Still their opinions were fixed, and they departed questioning the correctness of the decision of the jury.

Such cases show us the need of better education upon pathological and toxicological subjects. The best practical physicians are very often almost, if not wholly, ignorant as to what, in a cadaver, ought to be regarded as a product of disease, etc.

And even more ignorant as to all the bearings of toxicologi

cal questions. In this case, even, the fact that morphine had been found in the stomach by the chemist was brought forward as almost conclusive evidence that the patient had died from the effect of this drug, and even, as evidence, that it had been administered with criminal intent.

There is scarcely anything that shows more clearly than the above history the need of special knowledge, in deciding certain cases.

The teachings of the above cases are, as we take it, 1st. That the manner of calling experts, some by the prosecution and others by the defense, ought to be changed, because such a plan often acts injuriously as to right and justice, and brings disgrace upon the expert testimony; and, 2d. That knowledge goes hand in hand with honest purpose and cool courage, and as to knowledge, it is not every time the man who has seen the most or collected the most facts from personal experience that is the best adapted for such work. It makes no difference how the knowledge is gained, so he possesses it. The expert must have the tact to select what is recorded by others, as well as observed by himself, for a "walking encyclopedia" may be a very poor practical man.

As to honesty of purpose and cool courage, it is evident that, from the perusal of the above cases, we find that often experts may be honest, but ignorant; or they are rendered incompetent by dishonesty of purpose or by being confused or intimidated by counsel or surroundings. Now, in either of such cases, they certainly were not, at that time, true experts.

The time has come when, if the plan is permitted to continue in spite of the warning and contrary to the wishes of the medical profession, then the gigantic evil of *false expert testimony* must cease, by some means; and, if nothing else will stay its course, then the court record must be brought forth and arrayed before the profession, so that, if naught else will incite to *knowledge, honesty and courage*, fear of exposure must add its influence. This should, at least, be our object in all cases coming within the range of our observation. If we ourselves should trip, let some one perform that opinion for us, and in the same spirit of kindness that we propose to deal with others.

Reports on the Recent Progress of Medicine.

ARTICLE XXVI.

DISEASES OF THE RESPIRATORY ORGANS.

BY WM. PORTER, M. D.

[CONTINUED.]

27. Report on Membranous Croup and Diphtheria—Laneet, Oct. 26, 1878.
28. Observations on Pneumonia—Bemiss—N. O. Med. and Surg. Jour., July, 1878.
29. Contagious Pneumonia—Kuhn—Laneet, Aug., 1878.
30. Asthmatic Attacks at Night—Burkhart—Med. Press and Circular, Sept., 1878.
31. The Treatment of Asthma—Germain Sée—Laneet, Apr., 1878.
32. Action of Pilocarpin—Kurz—Chicago Med. Jour., Feb., 1878.
33. Prognosis in Tubercular Phthisis—Heitler—Wiener Med. Presse, 1878.
34. Cold Sponging in Tubercolosis—Pocagni—Memorabilien, Sept. 3, 1878.
35. Glycerine in Phthisis—Blacher—Le Currier Med., 1878.
36. Antiseptic Inhalations in Phthisis—Eade—Le Union Med., Sept. 3, 1878.
37. Climatic Treatment of Phthisis—Loomis—Am. Med. Ass. Trans., 1878.
38. Traveling in Phthisis—Pollock—Med. Times and Gazette, July, 1878.
39. Treatment of Early Phthisis—Fothergill—London Practitioner, Sept. and Oct., 1878.
40. Koumiss in Phthisis—Thomas—British Med. Jour., 1878.
41. Forms of Consumption Peculiar to Age and Sex—Pollock—London Med. Times and Gazette, 1878.
42. Amputation in Advanced Phthisis—Savory—Laneet, May, 1878.
43. Pulmonary Tubercle in the Carnivora—Houghton—Dublin Med. Jour., Aug., 1878.

27. At a meeting of the Royal Medical and Chirurgical Society, October 22d, the committee appointed to examine into the relations existing between the diseases known as membranous croup and diphtheria made a report of which the following is a summary.

1. Membranous inflammation chiefly affecting the larynx and trachea may arise (*a*) from diphtheritic contagion; (*b*) by means of foul water, air or other agents such as are commonly concerned in the transmission of zymotic disease; (*c*) as an accompaniment

of measles, scarlatina or typhoid ; (*d*) presumably from the inhalation of hot water, steam, acids or the presence of a foreign body in the larynx.

2. There is evidence that membranous inflammation has shortly followed exposure to cold, though in such cases the lesion appears to be of the nature of laryngeal catarrh.

3. Membranous inflammation to which the term "membranous croup" would commonly be applied, may result from an influence, epidemic or of other sort, which in other persons has produced pharyngeal diphtheria.

4. And conversely, a person suffering from the membranous affections known as membranous croup may communicate to another a membranous condition of the pharynx and tonsils, regarded as diphtheria. It will thus be seen that the membranous affection of the larynx may arise in connection with common inflammation or with specific disorders of several kinds, the most common of which is that which produces changes elsewhere and is recognized as diphtheria. In the larger number of membranous affections of the larynx the cause is obscure; common irritation is seldom the cause. Accidental injury is frequently productive of it, and but few cases have had an undoubted origin in exposure to cold, but on the other hand in a large number of cases, zymotic or infective influence is to be traced.

The membrane even when chiefly laryngeal, is more often than not, associated to some extent, with a similar change in the pharynx or in the tonsils, and it is not practicable to show an absolute line of demarcation between the laryngeal and pharyngeal forms of the disease. Facts warrant the conclusion, however, that when it occurs from zymotic cause or distinct infection and primarily affects the pharynx, constitutional depression is more marked, and albuminuria is more often and more largely present. The most marked division is that between membranous and non-membranous laryngitis.

The committee suggests that the term "croup" be used as a clinical definition implying laryngeal obstruction with febrile symptoms in children; their croup may be membranous or non-membranous, due to diphtheria or not so. The term diphtheria is the anatomical definition of a zymotic disease which may or may not be attended with croup.

The committee proposes that the term "membranous laryngitis" should be employed for the avoidance of confusion when

ever the knowledge of the case is such as to allow its application.

The committee consisted of Drs. Dickinson, Fagge, Gee, Payne, Howe, Semple and Greenfield.

28. In an unusually interesting article, Bemiss offers three propositions with reference to treatment. 1. We know of no therapeutic agents, which with any degree of success, arrest or abridge the morbid process of pneumonia. 2. The leading indication is to preserve or to render, the case as nearly typical as possible. 3. To treat any troublesome individual symptoms which may present themselves. Some objection will be found to the first proposition, but the author has experience and authority to justify his position. In elucidating the second statement he concludes that errors of type in pneumonia can generally be referred to some faulty state of the fluids at the date of the attack, and this condition should be combated by all possible means. In the symptomatic treatment (3) his recommendations are not new but, better than that, sensible. Fever is treated by quinine, cold diluent drinks and often by digitalis. Gentle purgation is employed when necessary. Pain is relieved by opiates (Dover's powder preferred) cupping, turpentine stupes, and sometimes by strapping the affected side, so as to prevent excessive movement. The patient may be placed in such a position as to compress the lung and thus limit the movement to some extent. Where there is aggravating cough, the "Brown mixture" with or without Dover's powders is preferred. If alcoholic drinks are not contra-indicated their anaesthetic effect over cough is often beneficial. Where a great amount of bronchial secretion forbids the use of opiates, carbonate of ammonia renders expectoration easier by diminishing the viscosity of the sputa, but care must be taken lest it produce intestinal irritation. Insomnia and delirium demands digitalis and opium, though good results have followed a rectal injection of forty grains of chloral dissolved in milk. Diarrhoea is an indication of opium, astringents and careful attention to diet. It often occurs that the substitution of a piece of chop or steak for the usual beef extract and fluid preparations will of itself be followed by better digestion and arrest of the diarrhoea. The hygienic treatment is important. The room must be well ventilated, the nurse quiet, and the physician himself should particularly prescribe the diet and enjoin upon the nurse every duty requisite to the comfort of the patient.

29. Kuhn has more than once observed pneumonia of epidemic form at Meringen in Hanover. On one occasion it broke out in the crowded jail, the cause appearing to be in the impurity of the air of the cells. The cases gave evidence of an infectious disease, with much prostration, a considerable enlargement of the spleen, albuminuria and diarrhoea. It did not begin as in ordinary acute pneumonia, with a rigor, but was ushered in with several days prodromal symptoms. The pyrexia was severe and pneumonic consolidation was recognizable on the third or fourth day, generally in the lower lobe and showed a tendency to migrate. Pleurisy was almost always present, and sometimes pericarditis and meningitis. The temperature sometimes reached 107°. Post mortem examination showed fatty degeneration of the heart, acute swelling of the spleen and a parenchymatous nephritis. The attendants of the institution were affected, and the disease was carried by visitors to other persons who did not come near the prison. In one epidemic Kuhn saw eighty-three and in another seventy cases. In each, abortive attacks of the disease were also observed. He urges that this be distinguished from croupous pneumonia and that its character approximates it to typhoid disease.

30. Burkhardt writes: The air of bedrooms, especially in winter, proves the most frequent cause of the "nocturnal" asthma. Notwithstanding the diminished energy of all the vital changes during sleep, at least one thousand cubic feet of air pass every hour through the lungs and return from them charged with more than four per cent. of carbonic acid, and completely saturated with water vapor; and the expired air contains ammonia, probably from decayed teeth or from particles of food decomposing in the mouth; also hydrogen, hydro-carbon and sulphuretted hydrogen, which, in consequence of a faulty digestion, may diffuse themselves into the intestinal veins and be eliminated by the breath. The products of perspiration and those derived from the combustion of candles, lamps and gas, contribute in their turn to increase the insalubrity of the place. It is known that air which contains one per mille. of carbonic acid is irrespirable, and its injuriousness is due, not so much, perhaps, to that gas itself—which, when pure, may without harm be inhaled in a somewhat larger quantity than is then present—but to the organic substances which always accompany it. Yet, even a slight excess of the

pure carbonic acid causes turgescence, a sensation of heat and pricking in the conjunctival and respiratory mucous membranes, while at the same time it increases the cutaneous and mucous secretions. In the presence of organic substances, however, a much smaller quantity of it becomes highly irritative. The inflamed mucous membrane of the respiratory tract seems particularly susceptible to its influence, and Hanke is led to conclude that the coughing fits in pertussis are traceable to that source. Now, however large a bedroom may be, a few hours' occupation of it will render it insalubrious in the manner just mentioned, unless the air be constantly renewed to the extent of at least two thousand cubic feet per hour and person. Unfortunately, asthmatics, as a rule, adopt no measures for the supply of fresh air. They rely on natural ventilation, or persuade themselves, if this matter ever receives their attention, that opening the door of the bedroom is all that is needed, but the consequence of that neglect is that, on account of the slow diffusion of gases, the patients are surrounded by their own noxious exhalations. As the temperature of the room is raised by respiration, foul gases from kitchen sewers, are attracted more readily than fresh air. After several hours the atmosphere becomes so vitiated that respiration is impossible, so that, toward morning, the patient is roused from his sleep by an attack of asthma.

31. In a recent communication to the Académie de Médecine, M. Sée advocates the employment of the iodide of potassium in the treatment of asthma. He used it in twenty-four cases of different varieties, and obtained good results in all save one. The dose he begins with is 20 grs. at meal times, for he holds that iodism is not more liable to be produced by large doses than by small ones, and that commencing iodism may often be aborted by increasing the amount of the drug.

32. Kurz treated a patient suffering from emphysema and severe bronchial catarrh by injecting under the skin a 2 per cent solution of pilocarpin. After ten minutes the paroxysm was less severe, the bronchial tubes were free, and the mucus readily expectorated. The remedy was repeated, and each time produced good results.

33. In a recent address, Heitler referred to the importance of being able to prognosticate the probable duration of different

cases of tuberculosis. After mentioning the different courses the disease might take, he concluded that, aside from the various complications, such as pneumothorax, meningitis, and considering age, heredity, etc., the physician must found his prognosis mainly on three conditions, the general nutrition, the local extent of the disease, and the occurrence of fever. In certain chronic forms of the disease the pulse will always be accelerated and the disease process progress, while there is but slight elevation of temperature. Intestinal complication is recognized by persistent diarrhoea. He claims that tuberculosis of the larynx is always secondary, and renders the progress very unfavorable. Haemoptysis affects the prognosis only through the three factors already mentioned. The point of greatest importance is the temperature, an increase of which is always an evidence of danger. In considering the relation of pregnancy to the tuberculosis, he believes that pregnancy does not in the least retard tuberculosis, and that its course and rapidity are precisely the same in the pregnant and non-pregnant woman. [Flint has shown that in 11½ per cent of married females under the age of 40 years who are phthisical the disease was developed during pregnancy. There is good reason, however, for the belief that the increased nutrition which generally attends phthisis is antagonistic to the progress of phthisis, but more than counterbalanced by the depressing influences attending labor and lactation.]

34. On waking, the patient sponges himself with water at from 50° to 70°F, or a temperature corresponding to the heat of the room. He then rubs himself well with a coarse towel, and returns to bed, where he lies quiet for an hour or longer, well covered up, but not sufficiently to cause perspiration. This treatment does not cause the shock induced by the cold douche recommended in tuberculosis by Brehmer, and is not contraindicated either by haemoptysis or excessive weakness.

35. Blacher advocates the use of glycerine in phthisis in combination with iron and arsenic. From a half to one ounce should be given daily.

36. The author recommends carbolic acid vapors to lessen the muco-purulent expectoration, and to diminish the cough in advanced phthisis. A little carbolic acid may be added to hot

water in a narrow-necked jug, and the patient should inhale the vapor, shaking the vessel occasionally, for ten minutes at a time, and repeat several times daily. It is also useful in bronchitis, stimulating expectoration.

37. Dr. Loomis says: I am led to believe that persons suffering from catarrhal phthisis do not do well at a higher elevation than 2,500 feet. My best results, in the stage of consolidation, have been reached in those who have made a prolonged stay in Northern regions, with an elevation of from 1,500 to 2,000 feet. Of such regions, the most positive and permanent beneficial results have been obtained in Ashville, N. C., and in the Adirondack region. My favorite resorts for those in whom acquired or hereditary phthisical tendencies exist, yet having no positive physical signs of lung disease, are Aiken, S. C., Enterprise and Gainsville, in Florida, and Thomasville in Georgia. [To this list we would add the table lands northwest of San Antonio, in Texas, especially for those who are able to bear camp life. Phthisis is in part a sequence of over-crowding, following closely in the wake of advanced civilization and acquired habits of life. Nature's antidote is to be found in out-door life, in a pure atmosphere, where the climate is not too changeable, and the altitude sufficient to stimulate nutrition and respiration. A slight difference in the atmospheric density will accomplish this; too much diminution is productive of irritation.]

38. In one of a well-prepared series of lectures on phthisis, Pollock, of Brompton Hospital, London, gives the following rules: 1. I never permit any patient to travel who is not in the quiescent stage of the disease, or who, in other words, is feverish with high evening temperature, with the physical signs and conditions indicating the continuous form of phthisis. 2. None of the secondary complaints should be present, as continuous or frequent diarrhoea, serious gastric disorder, or laryngeal irritation. 3. Chronic single cavity, with retraction of walls accomplished or proceeding, is favorable for removal to a dry, bracing locality if there be no tendency to haemoptysis. 4. That form of disease in which there is diffused deposits in one lung without much dullness or signs of massing of disease with large chest and moderate emaciation, generally does well on a sea voyage. 5. A first-stage case already chronic does best for traveling. 6. Persons with feverish symptoms, with secondary

complications, with a large amount of local disease in any stage, with both lungs diseased, with poor digestion and greatly lowered nutrition, or in such a state of weakness as to require home comforts, should not travel at all.

39. The first thing is to improve the general nutrition, so that the process of disease shall run a favorable course. It is not enough that good food, cod liver oil, etc., be employed. The leading characteristics of early phthisis are cough, emaciation, loss of flesh, night sweats and pyrexia. The most important matter is to check the night sweats, and the next is to "keep the stomach and intestines in good order, and attend to the assimilative process." If the sweats are not checked, the blood-salts drain out as fast as supplied; if the digestive powers are not cared for, the food taken is not assimilated, and so the patient is no nearer perfect nutrition and effective tissue repair. For the night sweats there is no remedy equal to atropia, but it must be given in sufficient doses, not less than the seventy-fifth, and increased to even the twenty-fifth of a grain. The night sweats of phthisis are very exhausting, as it contains chlorides, phosphates and sulphates, as well as urea, uric acid and traces of iron. Usually the first consequence of arresting the night sweats is the return of the appetite; food is both relished and digested. So long as this drain goes on it is useless to give milk, phosphites, meat juice, etc. etc.; it is like pouring them through a sieve. When it becomes necessary to exhibit opium or morphia for the night cough, it is well to combine atropia with it, for when deep sleep is produced the pulmonary respiration is lowered, the blood is insufficiently aerated, there is an excess of carbonic acid in it, and the sudoriparous glands are thrown into action. A pill in common use with the author consists of one-fourth gr. of morphia, one-fortieth grain of atropia, and three grs. of pile aloe et myrrh. The atropia often relieves the night sweating, and the morphia checks the cough and procures sleep while the aloetic vehicle prevents the bowels being locked up, and the appetite diminished by the action of the opium upon the local ganglia of the intestinal tube, and on the sensory nerves of the stomach. Sponging the patient with hot vinegar containing a considerable amount of capsicum is also effective in arresting the night perspirations.

Attention to the digestive apparatus is next in order. It is

of as much importance to watch the patient's tongue, which is the index of the condition of the intestinal canal, as it is to go over his chest with the stethoscope. When the tongue is covered with a thick fur it is useless to give iron and oil, which cannot be absorbed through the thick layer of dead epithelium cells. Here give a calomel and colocynth pill each second night, and phosphoric acid in infusion of cinchona thrice daily till the tongue is clean. When the tongue is raw and denuded of epithelium bismuth with an alkali and milk diet is most important. All drains upon the system must be stopped. In the early stages of diarrhoea a good effect may be produced by a pill of sulphate of copper, one-half gr., and extract of opium, one gr. Further on bismuth opium, and sometimes ipecacuanha are indicated. If the patient is a woman careful inquiry must be made in regard to menorrhagia and leucorrhœa. In menorrhagic women it is better to limit the loss of blood at the catamenial period than to build up the system in the intermenstrual interval, while leucorrhœa is a dead loss in every way. All inter-current disease or accident, as cold, must be guarded against, as likely to result in haemoptysis, which, though often fatal, is sometimes one of the best forms of local bleeding, unless the stage of softening is reached, when an artery may be invaded. In the early stages of phthisis, pulmonary hemorrhage is a less grave complication, as it generally relieves the pulmonary congestion. It is usually associated in early consolidation with constipation, which should always be relieved by applying hot water bottles to the extremities. Blistering may be of service when there are sharp pleuritic pains. The air should be free from all mechanical irritants, and perfect ventilation secured. The diet must be nutritious, consisting of meat-juice, milk and farinaceous foods. Beef tea is improved by the addition of biscuit powder, fine oat-meal or baked flour. Rice-water is indicated where there is diarrhoea; if there is constipation, fruit, cream and cakes of oatmeal and treacle are of service. If the patient is feeble, a glass of milk during the night, or a glass of rum and milk early in the morning should be given. A glass of sound wine may be taken at meal times, but the constant sipping of alcoholic drinks is unjustifiable. Alcohol should be taken as an adjunct to, not as a substitute for, food. Opiates to relieve the cough are condemned by our author; rather use bromide of potassium or hydrobromic acid and spirits of chloroform. If syphilis is a factor in a case of

phthisis there is less danger, and it is more easily amenable to treatment, such as the perchloride of mercury, and some preparation of iron. When the stomach and intestines are put right, a tonic (iron and strychnia or arsenic) is useful. Cod liver oil rarely does good unless there is a clean tongue.

40. In phthisis, in the early stages where the appetite is fickle, and in laryngeal involvement, where deglutition is painful, koumiss is an agreeable and good form of nourishment. It is less expensive than wine and may be used where stimulants are indicated. [To prepare koumiss, take a quart champagne bottle, put in two ounces of fresh yeast, and half an ounce of powdered sugar; then fill with fresh unskimmed milk, cork tightly and tie. Let the bottle stand in a warm place till the milk begins to thicken, and then lay it on the side in the cellar for a week. The result will be an excellent article of koumiss.]

41. This author says to early adult life belongs ordinary progressive phthisis, catarrhal pneumonia, phthisis with haemoptysis as an early symptom, the gastric and laryngeal complications, unresolved pneumonias and pleurisy originating phthisis. To middle life belong the chronic single cavity, chronic basic disease, and diffused deposit in the lung; so also the dust impaction from the mines, stove-dust, colliers and workshops; fibroid alterations of the lung associated with some of these conditions; and the more extreme instances of contracted side with displaced viscera, and secondary dilatation of the larger bronchi. In old age we find very chronic cavities, fibroid change, the chalky-gouty degeneration, and the combination of bronchitis, emphysema and phthisis. Old age, like childhood, is rarely subject to haemoptysis.

As regards sex, the results of many thousands of observations have shown some most interesting facts. In males there are many more cases of phthisis at puberty; they are more subject to profuse haemoptysis in the proportion of 267 males to 84 females. An arrest of phthisis occurred in 45 males, but in 23 females only. Chronic dry cavity in 122 males to 84 females; chronic second stage in 147 males to 119 females; chronic strumous phthisis in 155 males to 130 females. In phthisis occurring after forty-five years of age 174 were males, and only one-third were females. The combination of rheumatism, heart disease or gout with phthisis is more common in males, as 92 to 50. Slow senile

phthisis in 100 males to 21 females. In females the first stage was observed to be more prolonged, and slight haemoptysis is more frequent. The influence of pregnancy and lactation should be remembered in considering sex. Pregnancy appears to suspend phthisis, which is commonly precipitated after labor, but lactation accelerates it.

It is a common observation that hereditary cases do worse, as a rule, than phthisis which we call accidental—that is, disease acquired by habits or injurious influences, as trades, etc. Concentrated heredity, e. g., the intermarriage of two consumptive people, or the transmission through parents of hereditary disease from an ancestor on both sides, generally produces a rapid form of disease. Often, in childhood, tubercular disease of bone, glands, mesentery, brain, comes from this source; but if the individual lives long enough the lungs suffer. Again, forms of disease are transmitted, as very slow phthisis in parents and their children, of which I know many instances. There are families who cannot outlive a certain age, but die off, of phthisis, at twenty-one or twenty-five.

42. After detailing two cases of advanced phthisis in St. Bartholomew's Hospital, in which the lower part of the forearm was amputated on account of chronic suppurative inflammation, Mr. Savory concludes that phthisis is not always a counter indication for an operation such as amputation above the wrist. The risks of the operation are small, and the clean wound is substituted for the continued source of irritation. In both cases the healing of the stump was not delayed by the pulmonary condition, and the immediate results of the removal of the diseased joints were diminished cough, improved nutrition and lessening of hætic. The progress of the disease in the lung was not much affected by the operation.

43. These animals seldom die of true tubercle, but one case out of a hundred being noted. They often have either pure pneumonia, and generally die, even when very little of the lung is affected; or they have pneumonia with a kind of putrid fever called by the Germans *miltbrand*, accompanied by a purulent condition of the kidneys and softening of the liver. This proves fatal in seven or eight days.

ERRATUM.—Art. 20, last line, p. 275, in last number, read empyema, not emphysema.

ARTICLE XXVII.

DISEASES OF THE NERVOUS SYSTEM.

By C. W. STEVENS, M. D.

Dr. R. M. Bucke, Superintendent of the Asylum for Insane in London, Ont., has read two remarkably interesting papers before the Association of Medical Superintendents of American Hospitals for the Insane, the first one entitled "The Functions of the Great Sympathetic Nerve, the other, "The Moral Nature of the Great Sympathetic." Dr. Bucke is a profound and analytic reasoner and a concise and incisive writer, and his views and opinions on all subjects are always received by the Association with marked interest and attention. His view of one of the functions of this nerve is certainly a new departure, and his conclusions founded upon the anatomy of this department of our organism, and its adaptation to the moral or emotional nature, and also his demonstration of the like fitness of the cerebro-spinal system to the processes of perception, intellection and will, we think, are admirably sustained. The intellectual and moral natures, he argues, are entirely distinct from each other as to their seat or centers. He demonstrates that the sympathetic is far more extensive than is generally supposed; in fact that, taking into consideration the immense number of its ganglia, named and unnamed, distributed all through the viscera, the glands, the voluntary muscles, and in the coats of the vessels and its expanding fibers, it falls but little short in mass and weight of the cerebro-spinal system.

Leaving the main question, then, for the present, we intend only to present one of the points or issues of this subject, as we find it elaborated in the latter part of his second paper, viz: the longevity of the Jewish race, and the reasons for this interesting fact. He says: "Three thousand, five hundred years ago it was written, 'Honor thy father and mother, that thy days may be long in the land.' My argument is, first, other things being equal, those who have the highest and best moral nature live the longest; second, length of life depends upon the degree of

perfection of the great sympathetic nervous system; third, therefore the moral nature is a function of the great sympathetic. The first clause of the argument is, those who have the best and highest moral nature live the longest. I shall support this statement by four facts: First of these four is the extraordinary longevity of the Jewish race, a race which, to use Richardson's language, "has not only endured the oppression of centuries without being lost, but as it now exists, scattered here and there over the earth in different countries, and among the most varied social and natural conditions, is, of all civilized races, the first in vitality." This point will be found fully discussed in Richardson's last great work, "Diseases of Modern Life." M. Neufville found that in Franfort the average duration of the life of the Jews was forty-eight years and nine months. The civil state extracts of Prussia give to the Jews a mortality of 1.61 per cent, to the whole kingdom a mortality of 2.62 per cent. Taking into consideration all the data given by Richardson on this point, I estimate that the average life of the Jew is at least six or eight years longer than the average life of the non-Jewish inhabitants of the various countries in which the Jews live. Richardson goes on to say: "Different causes have been assigned for this higher vitality of the Jewish race, and it was indeed wise to seek for the causes, since that race which presents the strongest vitality, the greatest increase of life, and the longest resistance to death, must, in the course of time, become under the influences of civilization dominant. We see this truth indeed, actually exemplified in the Jews; for no race has ever endured so much or resisted so much. Persecuted, oppressed by every imaginable form of tyranny, they have held together and lived, carrying on intact their customs, their beliefs, their faiths for centuries, until, set free at last, they flourish as if endowed with new force. They rule more potently than ever; and far more potently than when Solomon in all his glory reigned in Jerusalem. They rule, and neither fight nor waste. Happily we have not to go far to find many causes for the highest vitality of a race which by comparison with the Saxon and the Celtic, is physically feeble. The causes are simply summed up in the term "soberness of life." The Jew drinks less than his "even Christian;" he takes, as a rule, better food; he marries earlier; he rears the children he has brought into the world with greater personal care; he tends the aged more thought-

fully; he takes better care of his poor, and he takes better care of himself. He does not boast of to-morrow, but he provides for it; and he holds tenaciously to all he gets. To our-Saxon or Celtic eyes he carries these virtues too far; but thereby he wins, becomes powerful, and scorning boisterous mirth, is comparatively happy."

The Jews, then, have an extraordinary amount of vitality. Why is this? The explanation which Richardson sees, is that they lead a more moral life than other people. Now, in the first place, no one, it seems to me, can suppose for a moment that there is enough difference between the Jew's outward life and the Christian's, to make this immense amount of difference in longevity. And in the second place suppose there was; why should Jews lead better lives than Christians? That they do lead better lives, I am prepared to believe. But why do they? What makes each one of us lead as good lives as we do? I do not say that our lives are good, but we all know that they might be worse than they are. Well then, supposing the Jews' lives are better than our lives, it is a fair inference that their moral nature is on an average, better; that it is higher than our moral nature; that with them love and faith are more fully developed, and hate and fear more restricted in proportion, than with us. But although these considerations are entitled to a certain amount of weight, I do not propose to rest this clause of my argument upon them. I have surer ground. That ground is the fact that the Jews have initiated the most advanced religions of the world during the whole course of its history.

Could a race with a low moral nature originate a high religion? No one, I fancy, will dispute, if he is capable of understanding what he is talking about, that the race which produced the law-givers, psalmists, prophets, and finally Jesus himself, was and is the race which possessed and possesses the supreme moral nature of this planet." Our author here cites statistics in relation to poets, musicians, painters, sculptors, philosophers, statesmen, clergymen, surgeons, merchants, lawyers, millers and mechanics, etc., the object being to show "that the average length of life of what we call great men is greater than it is among ordinary men, probably by six or eight years at the least." He comments upon the fact that married men and women live longer by some five years than those who are not married, growing out of the exercise of the emotional or moral

nature. The fact, as taken from Walford's Insurance Guide, that women live longer than men by some two to four years, he regards as important, because of the predominance of the emotions, especially; love he regards as favoring his leading idea. Finally he says: "If you adopt the hypothesis, that the moral nature is a function of the great sympathetic, there is a plain connection between elevation of the moral nature, and longevity; and what I say is, that to account for the facts you must adopt the hypothesis, for I say that the only explanation which will cover all the facts is that the moral nature being a function of the great sympathetic, and the great sympathetic being *par excellence* the organ of vitality, longevity and moral elevation are necessarily connected. The argument concludes by the proposition that "length of life depends upon the *degree of perfection* of the great sympathetic." I think you will agree with me that this proposition is almost self-evident since you all know that this system underlies and controls all the essentially vital functions, such as digestion, secretion, circulation, and above all, nutrition. Death is really, in nine cases out of ten, due to failure of the great sympathetic; for the degenerative changes which usher in and lead to death in old age, though they are more clearly seen by us to result from this failure, are really not more especially due to failure of nutrition, than are many other causes of death.

ARTICLE XXVII.

DISEASES OF CHILDREN.

BY W. E. FISCHEL, M. D.

THE FIRST NOURISHMENT FOR CHILDREN.—(Prof. F. A. Kehrer, Siessen-Volkmann, No. 70). From a teleological standpoint, the Professor asserts we must confess that, what the uterus is to the ovum during gestation, the mammae should be to the child until the appearance of the teeth will make it possible to assimilate more solid food. The mother's milk being then designed by nature for the nourishment of the child, is certainly best

adapted to its requirements. For this reason every mother should feel morally bound, if possible, to nurse her own child, and yet there are those who could do so if they would, but for some selfish reason, may be, will not. Neither will it suffice in such instances of obstinate passive resistance to refer to the evident purposes of the mammae. More impressive reasons must be resorted to. Such mothers may be reminded, that nursing the child is to an extent a protection against many uterine diseases consequent upon child bearing.

Suction of the nipples as is well known by reflex action, produces uterine contraction, which materially facilitates the regeneration of the puerperal uterus, thus operating to prevent enlargement and displacement of the uterus, chronic leucorrhœa, menorrhagic complications—causes that frequently lead to intractable hysteria or possibly to secondary sterility. Furthermore, it may be argued that mother's milk, being more easily digested than cow's milk, many of the diseases of early childhood are prevented, a more rapid and vigorous growth is encouraged, and finally, the mortality among children enjoying the privilege of nursing is far less than when nourished with any natural or artificial food.

The following statistics, prepared by C. Meyer (*Journal fuer Kinderkrankheiten*, 1871) will substantiate the truth of the last statement: Of 8,329 children under one year of age, that died in Munich from 1868 to 1870, 1,231 (14.7 per cent.) were nursed, and 7,078 (84.9 per cent.) were artificially fed. Such figures speak volumes.

Dr. Kehrer makes the following classification of nursing women.

- I. Qualified.
- II. Temporarily unqualified.
- III. Relatively unqualified.
- IV. Unqualified.

I. Qualified are such as have *a*, an abundant secretion of milk and good health; *b*, erosions of the nipples; *c*, mild puerperal fever; *d*, mild cases of sickness of any kind, especially; *e*, convalescents from rhachitis; *f*, venereal diseases, excepting syphilis, if contracted in the last two or three months of gestation.

II. Temporarily unqualified—*a*, flat or sunken nipples, until they have been elevated; *b*, deep or extensive ulcers of the nip-

ples; *c*, mastitis (the sound breast to be used); *d*, intestinal catarrh; *e*, dysentery; *f*, cholera.

III. Relatively unqualified—*a*, aligo and hydrogalactia; *b*, delicate constitution, decrepitness, debility; *c*, acute, and *d*, simple chronic anaemia; *e*, scrofulosis; *f*, acute non-contagious fevers (non-malignant).

IV. Unqualified—*a*, agalactia; *b*, galsetorrhœa; *c*, incurable mamillæ circumvallatae; *d*, chronic anaemia in consequence of deep seated organic disease; *e*, phthisis, or premonitory symptoms of same; *f*, syphilis acquired in the last two or three months of gestation; *g*, osteomalacia; *h*, malignant puerperal fever; *i*, acute exanthemata, variola, morbilli, scarlatina, diphtheria; *j*, non-contagious diseases accompanied with high fever and a tedious reconvalescence, as typhoid, pneumonia, rheumatismus articulorum; *k*, acute hysteria; *l*, epilepsy, psychosis.

Children who are deprived of their mother's milk should always, if it be possible, be supplied with a wet nurse. Due care should be exercised in the selection of such a one. Syphilis in the wet nurse is of all other diseases the most dreaded disease. We must make sure it does not exist. We cannot subject the nurse to a too rigid examination. Hard, round enlargements of the lymphatic glands, skin eruptions, psoriasis palmaris and plantaris, and other syphilitic affections; broad condyloma on mouth and genitals, ulcerated tonsils, hoarseness and difficulty of swallowing. All this must be kept in mind and looked for. We should also never fail to see the child of such a nurse. If it be a healthy, strong looking child, of good muscular development and an abundant supply of adipose tissue, we can exclude the likelihood of its having been nourished with unhealthy milk. A third class of children must be artificially nursed. Ass' and mare's milk are more readily digested, and in all respects come nearer the mother's milk, than that of cows and goats. Prof. Kehrer recommends that where stock raising of horses is practised a trial with mare's milk be made. He has good reasons, as we shall see further on, to promise a happy result. In the vast majority of cases we are forced to make use of cow's and goat's milk where artificial feeding becomes necessary. The current opinion that cow's milk differs from human milk only in the quantitative combination of its chemical ingredients, *i.e.*, that cow's milk can be made equal to human milk by adding water

and sugar, is false. It has been calculated, that the chemical analysis according to Gorup-Besanez of the two kinds of milk, being :

	HUMAN.	COW'S MILK.
Water,.....	88.908.	88.705.
Casein and Albumen,.....	3.924.	5.404.
Fat,.....	2.666.	4.305.
Milk Sugar.....	4.364.	4.037.
Salts	0.138.	1.548.

In order to make the latter equal to the former in the amount of protein and fat 60 per cent of water must be added ; to make it as rich in sugar, 2.4 per cent milk sugar to every 160 parts of the mixture. The main difference is not a quantitative one, but a qualitative. If vinegar be added to human milk there will be no change microscopically. If it be added to cow's milk, large cheesy coagula will be formed at once. Hydrochloric, sulphuric and nitric acids will not coagulate human milk if exposed to cold. Cow's milk, on the contrary, would under the same circumstances become thickly flocculent. That the casein contained in woman's milk and cow's milk differ in their reactions with most acids, alkalies and salts, Simen demonstrates in his inaugural dissertation as early as 1838. It has been generally thought and especially advocated by Scherer, that this was due to a difference in the composition of the serum. Professor Kehrer proves this to be erroneous, by an interesting experiment. If human milk and cow's milk be each filtered through an earthen cell, such as is connected with a galvanic battery, we will obtain four fluids, *i. e.*, two filtrates and two fat casein residuum. If now the residuum from the human milk be mixed with any quantity of the filtrate (serum) of the cow's milk, and vice versa, the residuum from the cow's milk with the serum of human milk, we will find that the former will not coagulate if reacted upon with acetic, muriatic, sulphuric and other acids, whereas the latter will. We must, therefore, conclude that the casein of human milk has a different chemical composition ; that in it the atoms are differently grouped than in the casein of cow's milk. The casein of ass' and mare's milk reacts with acids, etc., in almost every respect, as does that of human milk, whereas goat's milk resembles cow's milk.

TO BE CONTINUED.

CARBOLATE OF SODA IN THE TREATMENT OF WHOOPING COUGH.—Dr. Pernot considers carbolite of soda as a specific for whoop-

ing cough. He writes in the *Lyon Medical* (quoted in the *London Medical Record*) that it is a heroic remedy and would be almost a specific, if whooping cough could be cured at once. His cases have been numerous and have presented the following characteristics:

1. A notable diminution of the paroxysms of coughing after from two to ten days treatment.
2. Less labored and painful respiration.
3. Shorter duration of the paroxysms of coughing.
4. The most confirmed attack of whooping cough remains *in statu quo* from the commencement of the treatment, and it always appeared to him to diminish more or less rapidly, but always in a time relatively short to its usual duration.

Dr. Pernot operates in nervous affections of the bronchi in the following manner: He places the carbolate of soda in a small porcelain crucible held above the flame of a spirit lamp, which keeps it in an unvarying temperature as long as wished; the carbolate of soda becomes volatilized, so that scarcely any of it remains in the crucible, but the atmosphere of the sick room is impregnated with the vapor of carbolic acid mixed with the elements of coal tar. The little apparatus above described is not always at hand, but a fire brick is generally to be had either in town or country, and this, heated to a suffieiently high temperature to vaporize the carbolate of soda, is generally employed by Dr. Pernot. He also speaks very highly of the disinfecting and antiseptic properties of these vapors of carbolate of soda.

M. du Jardin Reanmetz states that when the carbolate of soda in the treatment of whooping cough was tried in the childrens' wards of the Hospital St. Antoine, although the results in whooping cough were not quite so rapid as those obtained by M. Pernot, it acted very thoroughly in the disinfection of the wards.—*Edinburgh Med. Jour. for July.*

MEMBRANOUS CROUP AND DIPHTHERIA—At the meeting of the Royal Medical and Chirurgical Society, held on the 22nd of October, Dr. Andrews presented the following report of the scientific committee appointed to examine into the relation existing between the diseases commonly known, respectively as membranous croup and diphtheria:

1. Membranous inflammation confined to, or chiefly affecting the larynx and trachea may arise from a variety of causes, as

follows: (*a*) From the diphtheritic contagion. (*b*) By means of foul water, of foul air, or other agents, such as are concerned in the generation or transmission of zymotic disease (though whether as mere carriers of contagion cannot be determined). (*c*) As an accompaniment of measles, scarlatina or typhoid, being associated with these diseases, independently of any ascertainable exposure to the diphtheritic infection. (*d*) It is stated on apparently conclusive evidence, although the committee have not had an opportunity in any instance of examining the membrane in question, that membranous inflammation of the larynx and trachea may be produced by various accidental sources of irritation—the inhalation of hot water or steam, the contact of acids, the presence of a foreign body in the larynx, and a cut throat.

2. There is evidence in cases which have fallen under the observation of members of the committee, that membranous affection of the larynx and trachea has shortly followed exposure to cold, but their knowledge of the individual cases is not sufficient to exclude the possible intervention or coexistence of other causes. The majority of cases of croupal symptoms definitely traceable to cold appear to be of the nature of laryngeal catarrh.

3. Membranous inflammation, chiefly of the larynx and trachea, to which the term "membranous croup" would commonly be applied, may be imparted by an influence, epidemic or of other sort, which in other persons has produced pharyngeal diphtheria.

4. And, conversely, a person suffering with the membranous affection, chiefly of the air passages, such as would be commonly termed membranous croup, may communicate to another, a membranous condition limited to the pharynx and tonsils, which will be commonly regarded as diphtheritic.

It is thus seen that the membranous affection of the larynx may arise in connection with common inflammation, or with specific disorders of several kinds, the most common of which in this relation is that which produces similar change elsewhere, and is recognized as diphtheria.

In the larger number of cases of membranous affection of the larynx, the cause is obscure, *i. e.*, in any given case it is difficult to predicate the particular cause in that case.

Among those in which it is apparent common irritation seldom presents itself as the source of the disease, accidental injury

is but very infrequently productive of it. But few cases of undoubted origin from exposure to cold are on record. On the other hand, in a very large number of cases, infection or zymotic influence is to be traced.

The membrane, even when chiefly laryngeal, is more often than not associated to some extent with a similar change in the pharynx or in the tonsils; and whether we have regard to the construction of the membrane, or to the constitutional state as evinced by the presence of albumen in the urine, it is not practicable to show an absolute line of demarkation (save what depends on the position of the membrane) between the pharyngeal and laryngeal forms of the disease.

The facts before the committee only warrant them in the view that when it obviously occurs from a zymotic cause or distinct infection, and primarily affects the pharynx, constitutional depression is more marked, and albuminuria is more often and more largely present, though in both conditions some albumen in the urine is more frequently present than absent.

The most marked division indicated by the facts before the committee is that between membranous and non-membranous laryngitis.

The committee suggest that the term "croup" be henceforth and wholly as a clinical definition, implying laryngeal obstruction occurring with febrile symptoms in children. This croup may be membranous or non-membranous, due to diphtheria or not so.

The term "diphtheria" is the anatomical definition of a zymotic disease, which may or may not be attended with croup.

The committee propose that the term "membranous laryngitis" should be employed for the avoidance of confusion, wherever the knowledge of the case is such as to allow of its application.

MELENA NEONATORUM.—In a paper read at the recent meeting of German naturalists and physicians, in Munich, (*Central Zeitung fuer Kinderheilkunde*) Dr. Lederer, of Vienna, expressed his regret that the melena of new-born infants was scarcely mentioned in modern text books on diseases of children. He had treated eight cases, of which five were fatal, from violent gastric and intestinal hemorrhage, together with bleeding from the umbilicus. The patients were all boys, the youngest sixteen hours and

the oldest fourteen days old; they were all mature and well developed; five were strong and well nourished, while three were tender and feeble; four had hemorrhage from both stomach and bowels; three from the bowels alone, and one from the stomach alone. In the cases which recovered, the discharge was arrested within twenty-four hours, the gastric hemorrhage always ceasing before the intestinal. A relapse occurred in one case only, at the end of twenty-four hours. In none of the children did a disposition for hemorrhage remain, but in nearly all there was a tendency to intestinal catarrh. Dr. Lederer regards the etiology of melæna neonatorum as not yet settled. He believes that the disease is not always the result of embolism, but that it depends on various causes, as it arises from single clots in the stools to violent hemorrhage. As a predisposing cause, he refers to the occurrence, in most of his cases, of hemorrhage from some organ in the father or mother. With regard to the treatment, he directs special attention to the fact that in all his cases the children were fed with breast milk by the mother or nurse. In the severe cases,iced compresses were applied to the abdomen. The internal treatment consisted in the use of a solution of session chloride of iron, nitrate of bismuth and tannite of quinine. The emaciation, anæmia and debility were treated in all cases by suckling alone, without any medicines.—*London Medical Record.*

Translations from the French.

ELEGY ON NELATON. By J. BECLARD. [Translated from *Le Progres Medical*, November, 1878, for THE JOURNAL. By S. POLLAK, M. D., of St. Louis.]

There are men, much neglected while living, who are more sensible of the suffrage of the few than anxious for the applause of the masses. They require a posthumous protest against the indifference of their contemporaries. In order to save them from oblivion, to place them in a proper light, they must be sought for and brought out from the shadow with which they loved to surround themselves. It is this work which we are about to undertake in reference to the eminent surgeon, Mr. Nelaton. He was never known to have courted the opinion of others. The love of work, supported by a firm will, a precocious maturity, a sound judgment, great ingenuity, added to good common sense, are desirable traits which cannot be acquired, but are precious adjuncts to personal charms. Add to these propitious circumstances, which are rendered the more favorable by his prudence and moderation. From the beginning of his career, he has been evenly advancing, without an instant's repose. He rose daily, until he reached the climax of contemporaneous French surgery, and achieved a reputation which neither time nor clime can retain.

Auguste Nelaton was born in Paris, the 17th of June, 1807, son of the upholster, Alexandre Francis Nelaton, who died in the campaign to Russia, and left the care of his son to his wife, who labored earnestly, faithfully and successfully to prepare him for his future career. In 1821 he was placed in some private institution, where he obtained the usual distinction of a well-spent college life. In 1828 he commenced the study of medicine at the Faculte de Medicine. In 1830 he entered, as *externe*, into the service of M. Dupuytren, and soon after he made a successful competitive examination for an *interne*, and was placed into the wards of M. Baffo, who, appreciating fully the talents of M. Nelaton, turned over to him the entire care of his clinics.

Our young *interne* did not let the rare opportunity escape which this great clinic afforded, which was especially devoted to diseases of children. Here he culled the material for his inaugural thesis, which was on "Tuberculosis of the Bones." For the first time was this dreadful disease carefully studied and analyzed, and clearly distinguished from serofullosis.

At this period, Dupuytren was to him the greatest prestige. To approach him, to attach himself to him, was the dream of his youth, his ambition to become one of his disciples. Nelaton never ceased to attend his lectures, and aspired to be some day admitted an adjunct to this great surgeon. In 1835 he was actually assigned to Dupuytren's ward in the Hotel Dien, but Dupuytren was there no more. He was kept away by a grave chronic disease, to which he succumbed on the 8th of February, 1835, at the age of 58 years.

In 1839, after a successful *concours*, he was appointed a member of the Faculty of Medicine and Surgery of the hospitals. This was in his 32d year. Success had, at that age, unexpressible charms, for it is more vividly felt—imagination embellishes the present with the promises of a still more brilliant future. The reputation of Nelaton began to spread abroad, but he still belonged to himself. The next ten years were the most fruitful of his scientific career, during which, thanks to his methodical and prudent life, he lived in assiduous intercourse with science, gave long hours to work, learned much, and prepared much for the future. It was then that he began his great work on chirurgical pathology, of which he could finish two volumes only. In 1850 he took part in the *concours* for the chair of operative surgery, in which Malgaigne was triumphant. In the following year he was more successful in another *concours*, by which he obtained the chair of surgical clinic, which his teachings made so illustrious.

French surgery emerged from obscurity about the year 1360, with Guy de Chauliac, and then, for two centures, it remained under a cloud until the advent of Ambrose Parè, and, for a long time after, only two men appeared who attained distinction: Petit and Desault, toward the end of the last century.

Dupuytren opened the present, who, educated in the schools of Hunter and Bichat, an experimentalist at a time when physiology had scarcely ceased to be merely speculative, an admirable instructor and lecturer, he soon was recognized as the first surgeon of his age.

Dexterity, celerity and neatness were the first requisites of a surgeon. *Technic opératoire*, (mechanical execution), held the first place; rapidity of execution thought the first necessity, but now they are deemed as secondary qualities. Surgery can only become a science when, in accordance with scientific medicine, operations are confined to the narrowest possible limit and to the smallest number. Bloody and destructive surgery is of the past; conservative surgery is of the present. To French surgeons this progress is mainly due, and to none more than to M. Nelaton.

The following historical event gave Nelaton an unparalleled wide-spread celebrity: On the 29th of August, 1862, at the battle of Aspromonte, Garibaldi, who fought for the unity and inde-

pendence of Italy was struck by three balls at the same time. One grazed the right hip, the other contused the right knee, the third penetrated the right foot, a little above and in front of the internal malleolus. All attempts, on exploration, to find the ball, proved abortive. The ablest surgeons of Italy explored the wound, and concluded—with the exception of Basile—the ball had been expelled. Nelaton arrived at Spezia the 28th of October, two months after the battle. At the first exploration he declared the ball yet in the wound. An ordinary probe introduced into the wound gave to his delicate and cultivated senses of touch and hearing a certainty which admitted of no doubt. This opinion was concurred in by Dr. Partridge, of London, and Pirogoff, of Russia, who arrived three days later.

On Nelaton's return to Paris he reflected upon the means by which the doubts of his distinguished Italian confreres might be removed. A few days later he sent them the instrument suggested by M. Emmanuel Rousseau. It consisted of a probe with an olive-shaped tip, white and unvarnished, upon which, by a rapid rotary motion, the leaden projectile must reveal its presence. On the 22d of November a little piece of compressed sponge was introduced to dilate the wound, and the next day Prof. Zanetti succeeded in the extraction of the ball with ease.

The name of Garibaldi, the gravity of events then enacted in Italy, the reputation of the Italian surgeons who diagnosed differently, the curiosity and public expectation, all concurred to popularize the French surgeon. The publicity given to the affair, which was re-echoed in the world, at once made Nelaton the most illustrious of his contemporaries.

From that time his surgical practice was incessantly growing, and it became immense. His popularity and success was only surpassed by his modesty. He treated his confreres with deference and respect, never permitting himself to overawe them by his opinion, which he frankly gave with modest reserve. In the last year of his life he was consulted in all difficult cases, and had to be the arbitor in all differences of opinion among surgeons.

On the death of M. Jobert he was called to the most envied and enviable post, as surgeon to the Emperor Napoleon III. This position, which he never sought, he knew how to make respected, in his person and the profession to which he belonged. Almost on the eve of the French national disaster the Emperor, in token of his gratitude and friendship, gave him a seat in that august body, the French Senate, but which was destined to vanish, as well as all other imperial institutions.

The preceding year Nelaton resigned his professorship. By this withdrawal from the faculty he hoped to retire from that devouring agitation which he had so long, but in vain, resisted. He was only sixty years of age, but his sight and health began to fail. He lost confidence in himself as his infirmities in-

creased. However, the crisis was on hand. Political events precipitated themselves, which culminated in the siege of Paris. Nelaton did duty in the ambulance. This last effort terminated in his breaking down entirely. A heart disease, of which he suffered so long, made rapid progress. His movements became difficult. An expression of fatigue and sadness replaced upon his amiable countenance the smile which used to overspread it.

In his last year the faculty of the department of the Seine elected him their President, and though utterly broken down by disease, he devoted all his energies to their interest.

At the express wish of his friends he consented to leave Paris, but neither Italy, the sea, or country could triumph over his incurable disease. He came back to Paris to die. Sunday, the 21st of September, 1873, was the last day of his life. He had reached his 66th year. His obsequies were without pomp. No speeches were made on his tomb. He desired absolute silence, and his will was respected. The funeral car was followed by few. Nothing which could recall to our mind the great state dignitary, the academician, the professor.

Proceedings of Medical Societies.

SOUTHWEST MISSOURI MEDICAL SOCIETY.

The semi-annual meeting of the Southwest Missouri Medical Society convened in Library Hall, Neosho, on Tuesday, November 12, 1878, at 2 p. m., Dr. Lewis Wills, of Neosho, President, in the chair.

The exercises were opened with prayer by Rev. J. B. Landreth.

The President delivered a very interesting inaugural address, welcoming the Society to Neosho, and proffering the hospitality of the profession and citizens, and dwelt at some length upon the responsibilities and arduous duties pertaining to the physician's vocation. He feelingly alluded to the generous sacrifices of those who had voluntarily braved the dangers of the late yellow fever epidemic, and paid a glowing tribute to those who had laid down their lives upon the altar of humanity and devotion to self-imposed duty, and recommended that the Society take some definite action in recognition of their noble service and heroic deeds. In conclusion he urged upon the members a thorough prepara-

tion for the practice of medicine, by careful study and observation, and a full and free expression of sentiments, and in the treatment of disease.

The minutes of last meeting were read and approved.

The President appointed as Committee on Credentials: Dr. Means, of Springfield; Dr. Maas, of Neosho; Dr. Matthews, of Carthage.

A recess of five minutes was taken to enable committees to report, and petitions to be presented, and upon resumption of business, the petitions of Drs. A. W. Chenoweth and J. C. Farmer, of Pineville; H. C. Dalton, of Neosho, and J. D. Mills, of Newton County, were presented, and having been each favorably reported upon by the Committee on Credentials, they were elected to associate membership.

The Committee reported, in addition to the above, the following gentlemen present, and entitled to associate membership: Drs. Matthews and Rhoads, of Carthage; Wills and Maas, of Neosho; Means, VanHoos and Flanner, of Springfield; Gore, of Pierce City; Launson and Harrison, of Newtonia.

On motion, Rev. J. B. Lee and Rev. J. B. Landreth, both former practitioners of medicine, were made members, by invitation.

On motion, a committee of three, consisting of Drs. Chenoweth, Gore and Matthews, was appointed to prepare resolutions relative to the labors and sacrifices of our medical brethren during the late epidemic of yellow fever, as recommended in the President's address.

Pending the report of the Committee on Scientific Communications, Dr. Flanner reported a case of angina pectoris terminating fatally, and raised the question, were opiates contra-indicated in organic affections of the heart.

A discussion followed, participated in by Drs. Means, Dalton, Rhoads, Matthews and Wills. The general sentiment seemed to be that while they should be used with caution, in cases where there was severe and continued suffering as in the case reported, the careful use of opiates was a necessity.

The reporter took the ground that in true angina pectoris there was always structural changes of the heart, and while he had not made a physical exploration of the heart sounds, owing to the sudden termination of his case, he believed the patient died from hypertrophy or dilation. This led to an interesting discussion, in which most of the gentlemen present took part.

Dr. Means, Chairman of Scientific Communications, reported papers for presentation and assignment thereof as follows:

Dr. L. P. Matthews, on "Use of Obstetrical Forceps, with Cases," 7:30 p. m., Tuesday evening.

Dr. Z. Van Hoos, "Changes in Animal Life," 8:30 p. m., Tuesday evening.

Dr. A. A. Maas, "Cholera Infantum," 9:30 p. m., Tuesday evening.

Dr. H. C. Dalton, "Pebbles Gathered on the Shores of Medical Knowledge," 9:30 a. m., Wednesday morning.

Dr. A. Rhoads, "Capillary Bronchitis," 10:30 a. m., Wednesday morning.

After the transaction of some routine business, a recess was taken to 7 p. m.

TUESDAY EVENING, 7 P.M.

Society met pursuant to adjournment, Dr. Wills in the chair.

Dr. Wills reported case of attempted suicide by hanging, and subsequent recovery, involving some points of medical jurisprudence relating to insanity. He also reported a case of suicide, in which the party, an old woman, survived five days after entirely severing the trachea, and opening the œsophagus.

Dr. Matthews read a paper on "Use of Obstetrical Forceps." This very interesting paper based on five cases occurring in the Doctor's practice, which were very clearly detailed, advocated the more frequent use of the forceps. He had practised obstetrics for ten years without what he had conceived a necessity for their use, but within the last two years had been compelled to employ them as described in the paper. He was satisfied that he had too much neglected their use heretofore and had allowed patients to suffer unnecessarily and hazarded the safety of both mother and child.

Dr. Dalton would withhold chloroform from the patient until after the forceps had been applied, thus availing himself of the mother's consciousness, to guard against grasping her tissues in the blades. He also thought there would be less liability to hemorrhage if chloroform was not administered.

Dr. Gore inquired whether in case of face presentation reported, podalic version would not have been a better expedient.

Dr. Rhoads had practiced medicine thirteen or fourteen years with fair obstetrical practice and had no occasion to use the forceps; thought we rarely met with cases requiring interference, and that our cases would terminate more successfully when instruments were not used. In his practice he had not interferred with face presentations and all had done well.

Dr. Flanner thanked Dr. Matthews for bringing this most important subject before the Society. The mass of the profession were either culpably ignorant or culpably careless, in withholding from suffering woman, the beneficent aid of one of the most useful but most neglected instruments of our art. Even though a parturient woman might after hours of suffering be safely delivered of a living child, and do well thereafter, in his opinion,

her obstetric attendant had no right to let her so suffer, when oftentimes he could with perfect safety, and, in fact increased security to both mother and child, terminate the case. In a large obstetric practice he had applied forceps as often as once in eight or ten cases and never had occasion to regret their use; was sure that we did positive good by their frequent and early use. Paid no attention to length of time the head had been in any given position; if the case was in any way delayed and nothing forbid their use, applied them without reference to continuance of the third stage. He had been taught to use Hodge's forceps, but of late years had used Bedford's and liked them. In ease of face presentation, would turn if he discovered the deviation sufficiently early; afterwards would always have his forceps ready and deliver the head at once. In reply to a query whether this would not be impossible he thought even if it was difficult the safety of the child positively demanded it, and he never had found any trouble in their application. Always gave the patient an anæsthetic if she wanted it and could hardly see how a careful man, with a good pair of forceps, could injure the mother.

Dr. Means approved of more frequent use of the forceps, but finds patients and friends so opposed to them that it often deters the physician from employing them; thought the risk of hemorrhage is in nowise increased by chloroform, as has been intimated by some.

Dr. Chenoweth had used forceps in but few cases, but believed they ought to be used oftener.

Dr. Mass had no experience in their use.

Dr. VanHoos very rarely used them and had got through his cases satisfactorily without them.

Dr. Wills had done a large obstetric practice in Newton County for twenty-eight years and never lost but one patient in child bed. He used forceps very rarely, but was satisfied that he sometimes ought to have done so when he had not. He strongly advised against the use of ergot in primipara.

Dr. Matthews closed the discussion with an able defense of the position taken in the paper and a summing up of the indications for the use of instruments, their application in various positions, etc.

Dr. Van Hoos now read a paper on "Changes in Animal Life." The doctor, in this learned, interesting and entertaining paper, after alluding to the metamorphoses occurring in the lower orders of creation, entered upon a somewhat metaphysical dissertation upon the origin, progress and development of man in reference to his past, present and future history. Reasoning from analogy and revelation, he argued strongly for the immortality of the soul, and gave the members some wholesome advice.

Dr. Maas read a very able and practical paper on "Cholera Infantum." After alluding to the clinical history of the disease and different modes of treatment, all of which had been very un-

satisfactory in his hands, he strongly advocated the use of Liebig's prepared food, conjoined with frequent cold baths, entirely eschewing drugs, and reported several illustrative cases.

Dr. Rhoads alluded to the great prevalence of this disease; some seasons and exemption in others; believed it to be a disturbance of the vaso-motor system of nerves. His attention had been accidentally called, several years ago, to the efficacy of a decoction of sumach leaves in this complaint, and he had ever since used it with great satisfaction. He gave it ad libitum as the stomach would bear it, and had never been disappointed in its use. He, like Dr. Maas, thought slightly of mercury, alkalies, astringents, etc.

Dr. Matthews had been dissatisfied with the treatment of the authorities; had found no benefit from mercurials, and for the vomiting preferred lime water.

Dr. Dalton thought the difficulty in the use of calomel was in giving too large doses, one-twentieth of a gr. being sufficient, and was usually well borne, and gave good results. He preferred cold friction to bathing. He had used with excellent results injections of carbolic acid in water as hot as could be borne, using $\frac{1}{180}$ to $\frac{1}{100}$ part of the pure acid.

Dr. Chenoweth, in his earlier practice, had used calomel in small doses with ipecac with apparent advantage, but latterly had been disappointed in its use. Had used pepsin with good results.

Dr. Matthews reported a case of cholera infantum, or inflammatory diarrhoea, with very offensive evacuations and ulcerative stomatitis, in which rapid recovery followed the use of carbolic acid per orem.

Dr. Rhoads wished again to insist upon the efficiency of decoctions of sumach.

Dr. Means deprecated the disposition to condemn calomel in disturbances of the alimentary canal. We certainly had no remedy which so certainly relieved hyperaemia and promoted secretion. The difficulty was in not knowing just how to use it. He frequently relieved cases of long continuance by repeated small doses of calomel.

On motion, a recess was taken to Wednesday morning at 9 o'clock.

WEDNESDAY MORNING, 9 A. M.

Society met pursuant to adjournment, Dr. Wills in the chair. Pending the reading of Dr. Dalton's paper, he having been called out, Dr. Farmer asked the opinion of the members as to the use of quinine in pregnant women suffering from intermittent fever.

Dr. Rhoads had never hesitated to give cinchonidia or quinine

in such cases, and cited a case where abortion was threatened as the result of malarial poisoning, in which, by the use of emenagogues, uterine contraction had been quieted and his patient went to term.

Dr. Matthews also cited a case in which miscarriage had occurred at the seventh month, but he attributed it to malaria, not to remedies.

Dr. Wills treated pregnant women with intermittents precisely as in any other case, and had never observed its oxytotic effects in such cases. He also took occasion to enforce the propriety of trusting the *vis medicatrix naturae* more than many are accustomed to, and administering remedies only when there was a positive indication therefor.

Dr. Means thought quinine would produce no more tendency to abortion than any other remedy which produced a positive impression on the nervous system. He spoke of the use of quinine by injection or application to the skin in solution, and its particular usefulness with children or irritable stomach.

Dr. Maas reported a case of morbus coxaria in a child aged 1 year, with hereditary serofulous taint and suppuration of mastoid cells. He applied Sayre's apparatus, which acted admirably, but was compelled to discontinue it on account of excoriation from urine coming in contact with apparatus, since which he had applied no extension, but with supporting treatment and favorable hygienic surrounding, the case was going on better than might be expected.

Dr. Dalton read a paper entitled "Pebbles Gathered from the Shores of Medical Knowledge." The Doctor, while disclaiming an advocacy of the expectant treatment of disease, thought slightlying of the great number of new remedies introduced and vaunted highly for their specific properties; we needed more careful study of disease and therapeutics as a basis for a sound medical philosophy. He alluded to many of the modern triumphs of the science of art and medicine, and the incentive to redoubled efforts in that direction. He dwelt at some length on the etiology and treatment of yellow fever and other zymotic diseases. This excellent paper received the close attention of the Society, and elicited remarks from many of the members.

On motion of Dr. Dalton, Dr. R. C. Green, of Dayton, was made a member by invitation.

Dr. Rhoads read a paper on "Capillary Bronchitis," which treated succinctly and clearly of the differential diagnosis of this somewhat obscure but important disease, which served as the basis of a discussion participated in by most of the members.

Dr. Matthews cited a case of esophageal stricture from drinking lye, followed by capillary bronchitis, and terminating fatally. All the members found this disease a very formidable one and very rebellious to treatment.

Dr. Lamson, Dr. Matthews and Rev. Dr. Landreth each re-

ported a case of cerebral effusion or hemorrhage, and a very general discussion took place on this and kindred subjects.

The committee to whom was referred the President's address made the following report, which was, on motion, adopted and ordered to be published:

The committee to whom was referred the address of the President would respectfully beg leave to submit the following as to that portion of the address referring to yellow fever sufferers:

WHEREAS, In the recent epidemic of yellow fever in the South, great opportunities were offered to our profession to test their skill and self-sacrificing heroism; and

WHEREAS, A great scarcity of physicians in many localities in consequence of the general prevalence of this fearful scourge, rendered it necessary that volunteer service be offered to supply the want; therefore, be it

Resolved, That we refer with pride and the highest admiration to those brave men in our profession who marched boldly forward in the path of duty, ministering to the sick and dying who were the victims of this mighty pestilence, and, in many cases, falling nobly at their posts of duty; and this exhibition of heroism upon the part of our brethren in other parts of the country should stimulate us to a more faithful and conscientious discharge of our professional obligations in our various fields of labor.

A. W. CHENOWETH,
L. I. MATTHEWS,
D. C. GORE,
Committee.

The thanks of the Society were, on motion, tendered to the profession and citizens of Neosho for their generous hospitality, to the Library Association for the use of their hall, and to the gentlemen of the press for attendance and kindly offices.

Whereupon the Society adjourned to meet at Springfield, the second Tuesday in May, 1879, at 7:30 p. m.

THOS. U. FLANNER,
Recording Secretary.

TRI-STATE MEDICAL SOCIETY.

The Tri-State Medical Society of Illinois, Indiana and Kentucky began its annual session in Springfield, Ills., Wednesday, November 13th, 1878, with a fair attendance. The Society has a membership of about 180 prominent physicians from different sections of three States represented. As it has no special code of ethics to defend, any physician in good standing presenting certificates from a State, county or district medical society, or the American Medical Association, is eligible to membership.

The Society met in Representative's Hall. The meeting was called to order by the President, Dr. J. F. Hibberd, of Richmond, Indiana, who introduced Judge Jas. H. Matheny, of Springfield, Ills., who delivered the address of welcome, substantially as follows:

MR. PRESIDENT AND GENTLEMEN: It may appear strange for a man, whose business it is to administer upon dead men's estates, to appear upon an occasion like this, and to pronounce an address of welcome to an assemblage of doctors, whose business it is to prevent the near approach of such administrations. However, it remains for an old settler to extend you a hearty welcome. When I came to this section of the State I saw but few traces of civilization before me. I recall to-day the grand good men, Drs. Philo, Todd, Jayne, Early and Merriman, who, a half century ago, entered this, then sparsely settled country, and with the robust courage of angels in their souls, blazed the way for you who to-day stand high in your profession. They may not have had diplomas which indicated as much learning and erudition as the members of this body possess, but they were heroic and served well their time and generation. They journeyed many miles through snow and hail and across bridgeless streams to minister to the wants of the pioneer. They were true Knight Errants. They never faltered. My best wish is that in after years the records of each one of you may call up as many affectionate remembrances as does theirs to a number of us old men who still linger on this side of Death's boundary line. The profession of medicine is an important one and to my mind one of the most important. It remains for the faithful physician to bring the lawyer back to the forum, the minister to his sacred desk and the mechanic to his shop. In the medical profession I many, many times behold the evidences of true devotion which I seldom see presented so prominently anywhere else. And now, in the name of the old citizens of Springfield, and in the name of the middle aged, and the young of this city, and in the name of all of her citizens, I bid you again a hearty welcome. May

you continue to attain higher positions in your profession and, while you live, prove a joy and a blessing to the race.

A graceful and polished response to the Address of Welcome was delivered by Dr. Theophilus Parvin, of Indianapolis, although comparatively without deliberation. "Not till the eleventh hour, or rather between 8 and 9 this morning" as he said, "being notified that he would be expected to perform the duty in the absence of Dr. David Yandall, of Louisville, to whom it had been assigned. Premising that he wished he were a Kentuckian, not only to inherit the fame of such men as McDowell, Dudley, Miller and others distinguished in the profession,

"Tongues all dead, not lost,
But speaking from death's frost
Like the tongues of fire at Pentecost,"

but also that he might be touched with a little of the fire of Kentucky eloquence, and contrasting the treatment of himself in being thus taken by surprise and assigned upon a moment's warning to the task of a month with the practice of the Venitians who a month before an attack sounded their matinella not to arouse Venitians but to put the enemy on their guard—sometimes nowadays friends by friends being treated worse than foes by foes used to be; and after quoting lines from "one of the sweetest speaking, one of the gentlest voiced and of the purest hearted of English poets that ever lived" expressive of the sentiment of common brotherhood and sympathy peculiarly the bond of a profession whose business it is to minister to the suffering of the human race, which instead of dividing as some one had done, into those who have been to Paris and those who expect to go there, he would divide into those who have suffered and those who expect to suffer. Alluding to the fact that Charles Dickens for the establishment in London of the Charity Hospital for sick children, had used the double argument, not merely that it would benefit the poor, but also that it would prove a profitable investment for the rich in the way of a school for the advancement of science. The speaker said so the meeting of members of the medical profession would result in a double advantage, not simply to the members themselves who took part in such meetings, but also to their clients, who in the etymological sense of the word, *leaned* upon their skill. The speaker concluded as follows:

"In the name of the gentlemen of Kentucky and Indiana, especially, let me thank you for your kind welcome. Our hearts may feel more than our tongues can tell. As in the old painting of the sacrifice of Iphigenia, it is said that the painter drew a veil over the face of Agamemnon as if there were no power in his art to express the deep sorrow of the father at the fate of his daughter. So it may be and it is that our words are feeble to express the gratitude we feel for the kindly welcome that you

have given us. And finally, gentlemen, since it has been said "speech is silvern but silence is golden," and since I have given you such silver as I had, please now take my gold.

These preliminary proceedings concluded, the report of the local Committee on Arrangements was presented, and the order of the proceedings for the sessions decided upon, after which a recess was taken for dinner.

The session was resumed at 2:30 o'clock, with an increased attendance. First in order came the President's annual address, which was delivered by Dr. J. F. Hibberd, of Richmond, Ind., who, instead of discussing the mission of the Society, called attention to some special views of his own concerning the nature and primary manifestations of nerve functions, and then to some general considerations regarding the practical significance of the information coming to us through the modern investigation of nerve structures by a host of diligent students. A change of thought amounting almost to a revolution has been effected by the doctrine of biology that all vitalized matter is compressed in cells or the immediate product of cells, and that all animal existence is comprised of one or more cells, each cell retaining in some degree its characteristics of independence. Yet this doctrine is to-day accepted by every thorough biologist. Recent investigations, if persevered in, will open to us as accurate an insight into the occult structure and mysterious operations of the nerves as we now have of the nature and functions of cells.

The Doctor then entered into an elaborate and scientific review of the various theories in regard to the origin and relation of the nerves. He answered the query as to how a fascicular or whole muscle is exerted to contraction by a nerve force applied to a single point by the statement that it was by virtue of the fact that the cells which compose the muscles have, by the law of their evolution, retained so much of the endowment of the primordial animal cell as qualifies it for this necessary duty.

He next examined the system of nerves in some phases of their highest development. The difference between Rev. Joseph Cook and Col. R. G. Ingersoll, he said, is a difference of nerves; so is the difference between Gen. U. S. Grant and Gen. B. F. Butler; between Prince Bismarek and Sitting Bull of sorrowful memory; between Thos. A. Edison and Dennis Kearney; between Herbert Spencer and George Francis Train; between Florence Nightingale and Victoria Woodhull; between Shakespeare and Milton; between Tennyson and Walt Whitman. The differences spring out of the dual base of heredity and cultivation, both of which pertain to nations and races as well as individuals.

The Indian policy of the United States will never be true or just until it is based on a proper appreciation of the nerve development of the aborigines. An Indian is a man physically, but

a boy in reason, morals and religion. No management of the Indians can be successful that does not recognize the status of his nerve development, and proceed on the fact that this status can only be altered to our standard of civilization after several generations of training, and never on the adult individuals on whom it may be begun. Such a change must be the joint work of heredity and cultivation.

Woman's right is another question of State, large now and rapidly growing, that must be adjudicated on the basis of a knowledge of the nerve status of the sexes. No abstract reasoning on the fanciful equality or dissonance of the sexes can settle the question; neither will a retrospective view of the status of women in the barbarism of the past, nor a prophetic forecaste of what it may be in the future, nor yet a true estimate of what a woman may do or may not do in other civilized countries of to-day; the problem is absolute for this country at this time, and must be solved by reaching a correct understanding of woman's nerve development either by scientific investigation or hap-hazard drifting. Suffrage is not a natural right, like fighting, for instance, but is a privilege growing out of the aggregation of people into a community such that same natural rights must be yielded to the common welfare, and same artificial organization established to regulate public affairs, and must be exercised according to these adopted rules, and these will always be in accord with average nerve developments of the community.

The President's address was referred to the Publishing Committee, and a vote of thanks to Dr. Hibberd was returned by the Society, on motion of Dr. Parvin.

The Metric System was next explained in a brief paper by Dr. David Prince, of Jacksonville, after which a blackboard was procured, and the system illustrated in crayon by the Doctor.

Dr. Fairbrother, of East St. Louis, offered a resolution approving the system, and recommending it to the State Legislatures. The resolution was lost by a large majority. Although the members seemed to approve, they did not think the Society ought to take action on such subjects.

The next paper was upon "Muscular Rigidity; a Cause, Symptom or Result of Disease," by Dr. J. L. Holloway, of Louisville, Ky. This was an able one, and a brief extract would not do it justice. It elicited considerable discussion, after which a recess was taken until evening.

SECOND DAY.

The second day's session of the Tri-State Medical Society began at 9 o'clock in the morning, President Hibberd in the chair. First in order came the reading of Dr. Theophilus Parvin's paper on "Perineoplasty," which was listened to with close attention, and discussed by Dr. Freeland and Dr. Holloway. The paper was then referred to the Publication Committee.

Next came a paper upon "Modes of Administering Mercury in Syphilis," by Dr. J. W. Thompson, Paducah, Ky., which was discussed by Drs. Keller, Holloway and Freeland. This was followed by an address upon the subject: "Sections of the Superior Maxillary Nerve," by Prof. John T. Hodgen, of St. Louis.

The subject was treated in an able manner, and was discussed by Dr. Jewell, Dr. Freeland, Dr. Rumbold, Dr. White, Dr. Owen and Dr. Singleton, after which the paper was referred to the Publication Committee.

A paper on "The Principles and Practice of Modern Lithotomy," by Dr. R. A. Vance, of Gallipolis, O., was next read. An interesting discussion upon this subject followed, participated in by Dr. Prince, Dr. Owen, Dr. Reber, Dr. Gregory, Dr. Keller, Dr. Hodgen and Dr. Jewell. The paper was referred to the Publication Committee.

At the afternoon session, the reports of the Secretary and Treasurer were read and approved.

A paper upon the methods of local treatment of scarlatina was read by Dr. Thomas F. Rumbold, of St. Louis, and discussed by Dr. S. J. Johns, of Chicago, and Dr. S. P. Jones, of Indiana.

An interesting event of the afternoon was the address delivered by Prof. J. S. Jewell, of the Chicago Medical College, and editor of the *Journal of Mental and Nervous Diseases*.

The report of the Committee on Nominations was presented and unanimously adopted, the following being chosen officers for the ensuing year:

President, Dr. J. A. Ireland, of Louisville; First Vice-President, Dr. J. W. Compton, of Evansville; Second Vice-President, Dr. B. M. Griffith, Springfield; Third Vice-President, Dr. J. M. Holloway, Louisville; Secretary, Dr. G. W. Burton, Mitchell, Ind.; Treasurer, Dr. F. W. Beard, Vincennes, Ind.

Chairmen of Committees—On Surgery, Dr. J. M. Keller, of Hot Springs, Ark.; Practice of Medicine, Dr. S. H. Charlton, Seymour, Ind.; Obstetrics, Dr. J. W. Singleton, Paducah, Ky.; Gynecology, Dr. H. B. Buck, Springfield; State Medicine and Hygiene, Dr. Thad. M. Stevens, Indianapolis.

Place of meeting, Evansville, Ind. Time, first Tuesday in November, 1879.

Dr. J. A. Ireland, of Louisville, presented the next paper; subject, "Pelvic Cellulitis." The paper was a lengthy one and full of interest to the profession. Like the others, it was referred to the Publication Committee.

Drs. Burton, of Mitchell, Ind., Griffith, of Springfield, and Beard, of Vincennes, were named by the President as the Publication Committee for the coming year.

"Finger Stumps" was the subject of a paper by Dr. Fairbrother, of East St. Louis, who discussed the methods of treating the fingers in surgical operations.

The attendance was largely increased in the evening, on the

occasion of the lecture delivered by Prof. E. H. Gregory, of St. Louis, which was both instructive and entertaining. The Doctor displayed unusual ability in word painting, and his elegant dictation was evidently appreciated by his auditors. He considered man, first in comparison with other animals, explaining the development of various forms of animal life, and their relations to each other, concluding with an eloquent tribute to man's mental and moral superiority.

At the close of the lecture, the visiting physicians and others repaired to the Executive Mansion, in response to the Governor's invitation. The reception was a compliment which the strangers highly appreciated, as it not only formally attested the hospitable nature of their welcome to the State and the Capital City, but also offered them an opportunity of witnessing something of Springfield society.

A number of prominent citizens, including quite a representation of young people, were present. The guests were received by Gov. and Mrs. Cullom, assisted by the Misses Cullom and Miss Fisher. The occasion was enlivened by the presence of the German Band, and the music was improved by the devotees of Terpsichore. The occasion was a thoroughly enjoyable one in every respect.

THIRD DAY.

Dr. Thad. M. Stevens' paper, "Some Thoughts on Medico-Legal Questions," was read by title.

Dr. Sarah H. Stevenson, of Chicago, read a paper on "Education of the Senses," which was recommended very highly:

The great fault of the old system of education is that it begins with the upper part of the nervous system. It appeals to the judgment and reason, *of which there are none*, and neglects the feelings and sympathies, of which there are an abundance. Abstract ideas are fit only for mature minds. Yet an alphabet comprised of twenty-six letters, most absurdly abstract ideas, are driven into the infant brain. The A B C and the multiplication table are a good introduction to abnormal stupidity, or abnormal precocity. In the one case the higher centers repel the stimulation in the other they respond, but at the expense of their own structure. The Polytechnic school of Paris is said to produce the best scholars, and the greatest amount of insanity of any school in France.

Dr. J. M. Keller, of Hot Springs, Ark., read a most interesting paper on "Yellow Fever." The doctor gave an interesting review of the commencement of the epidemic, and its progress northward from New Orleans, reviewing the various measures taken to prevent its spread, and suggesting how they might have

been more successful. He believed in rigid quarantine, and highly complimented the Local and State Board of Health for the quarantine measures they had inaugurated at Cairo. It was his opinion but for those measures the Southern portion of the State, if not the whole State, would have been afflicted with the scourge. Adjourned.

AFTERNOON SESSION.

Dr. J. W. Compton, of Evansville, followed Dr. Keller, with a second paper on yellow fever. He believed the poison was a solid, not of any form of life; that it attaches itself to walls and exposed surfaces; could be communicated from one person to another by contact.

The Steamer Porter, the pestilence boat, demonstrated the transportability of the poison. He gave numerous instances to sustain this proposition. He believed the only preventive to be a strict quarantine.

Dr. A. R. Vance, of Gallipolis, gave the history of the Porter, and the epidemic at that point. He related many affecting incidents of the scourge.

The President appointed a committee on quarantine to report at next meeting, to wit: Dr. J. M. Keller, Hot Springs; Dr. D. H. Chase, Louisville, Ills.; Dr. E. S. McIntire, Mitchell, Ind.

A number of papers were read by title and referred.

Adjourned.

EVENING SESSION.

According to the previous announcements, the Society was to close with a "Micropscopical Soiree," under the direction of Dr. S. L. Mathews, of Springfield. There were some thirty-five instruments present, and objects of every description.

On entering the hall and turning to the left were found the instruments of the Jacksonville Society, 14 in number, next were two tables of Dr. Mathews, containing 8 of the most splendid instruments ever exhibited in this country; next to him were the tables occupied by Dr. Lindsay and Dr. Burton. Then came the tables of Chicago Society, 12 instruments, with Prof. Danforth and Mr. J. G. Langguth. Among the objects exhibited circulation of the blood in the lung and foot of the frog, deep sea soundings, parasites, botanical specimens, infusions and pathological specimens, without stint, etc. Taking it all in all it was a most brilliant, interesting and instructive entertainment, and one that will be remembered by all who had the pleasure of being present.

After a vote of thanks to Geo. C. Calhoun, the officers, and citizens of the State and city, and with a kindly feeling for each other, the Society adjourned to meet in the City of Evansville, on the first Tuesday in November, 1879, at 11 A. M.

Clinical Reports from Private Practice.

A CASE OF OVARIOTOMY. By EDW. BORCK, M. D., ST. LOUIS, MO.

The following is the previous history as furnished me by the family physician, Dr. Thomas O'Reilly:

"Miss Jessie J. S., accompanied by her mother, called at my office July 14th, 1877. She was a school girl about fourteen years old, and had menstruated regularly for a year and a half. Her general health was good, but in the region of the left ovary there was a diffused swelling, unaccompanied with fluctuation or defined border. I informed the mother that the tumefaction was ovarian, but I could not then determine its exact nature; ordered a mild diuretic aperient and iodine paint, and directed her to call again at my office in a week. On the 21st of July she was again examined, when I felt satisfied of the presence of fluctuation, which determined me in the opinion that it was an ovarian cyst. From this date until March 16, 1878, I saw her occasionally; saw her in consultation with Dr. Hodgen, who confirmed my diagnosis. Dr. Gregory, who was to have met us on this occasion, being prevented from so doing, saw her some few days later, and fully concurred in the diagnosis. At this time the tumor had become greatly enlarged and more circumscribed. As there was nothing new to suggest, I did not see the patient again until the 6th of October, when the father called upon me to say that he and his family had fully determined on ovariotomy, and that he had selected Dr. Edw. Borck to operate; I visited my patient in conjunction with the Doctor, who will continue the history of the case.

Thos. O'R."

Mr. and Mrs. J. S., residing at No. 104 South Fifteenth Street, City, consulted me in the beginning of September, 1878, concerning their daughter Jessie, aged fourteen years, ten and a half months—American. She is about five feet four inches high, blue eyes, reddish brown hair, cheerful and lively temperament, of good education.

Pulse before examination, 90, afterwards 100; diagnosis ovarian tumor; gave no opinion.

I saw her again about two weeks later; pulse before examination 86, soft and regular, afterwards 92; well expressed facia ovariana; face and upper extremities emaciated; skin fair; no oedema of legs and feet; measurement around the umbilicus fifty-two inches; veins of abdomen prominent; on deep inspiration the abdominal walls could be seen moving over the tumor, and could be lifted up by the hand; respiration rather hurried, 32; men-

struation regular but scanty up to a month ago, when it ceased; no trouble with the urine, bowels tolerably regular, appetite not very good; does not care much for substantial food; tongue slightly coated; percussion sound dull; fluctuation distinct. No examination per vagina nor neumet for obvious reasons. The case was a well marked *single cystic tumor*.

The patient's condition was onerous, still she seemed to carry her misfortune with great fortitude, and desired to be relieved if possible, such being also wish of the parents. Tapping was discarded, as they rightly understood that the relief would be but temporary, and in her present state it was evident that she could not very long survive, as the cyst was filling up, and, her health rapidly failing, inanition was more developed than her appearance indicated. The consideration for an operation was only left then as a last resort, and the only hope of saving her life.

I carefully explained the danger of an operation to the family. Though I regarded this case itself rather favorable for an operation, I avoided giving them any encouragement whatever towards success, and made no promise, except that if they should select me I would operate and give all the attention possible. Advised liberal diet and fresh air.

October 6th I saw the patient in consultation with the family physician; no change. After mature consideration and consultation on the part of the family, they decided for the operation. The 15th of October, 12 o'clock m., was selected; accordingly all preparations were made as in my previous cases. The patient was in good spirits, and seemed confident of recovery.

The evening before the operation an enema was administered to evacuate the bowels; a cup of milk and bread allowed.

On the morning of the operation, after bathing, she was dressed with a short gown, flannel drawers and stockings. A cup of milk and bread allowed; the patient was then put into an easy chair, kept quiet, wrapped up in blankets, warm water bottles put to her feet, and room steamed with hot water to keep her moist. This is essential; dry cold skin would be a disadvantage. The operating room being prepared, the assistants all exposed themselves for some time to the spray of a solution of carbolic acid, and washed their hands in carbolized water.

The patient was brought in, and having been placed in her ready made bed, and with the able assistance of Drs. D. V. Dean, Thomas and Robt O'Reilly, Chas. J. S. Digges, E. A. Vogt, Mr. Alex. Heburn and Sister Micheale, of the St. Marien Convent, I proceeded: Chloroform was administered, but after a few whiffs she began to vomit, and sulph. ether was substituted. I made an incision through the skin about two inches long, below the umbilicus in the linea alba; she vomited again; dissected down to the peritoneum; after all hemorrhage ceased, divided it, having satisfied myself that there were no adhesions, I lengthened the incision about three inches toward the pubis; this exposed well

the bluish looking cyst; thrusting my elevator into the sac I introduced the trocar and drew off the contents; none of the abdominal viscera protruded; the cyst was then entirely lifted out of the abdomen; the pedicle was short and not very thick; clamp applied; below this a single and one transfixated catgut ligature applied; pedicle cut and clamp removed; the pedicle contracted and part of it slipped from under the ligature; some hemorrhage ensued, but prevented from running into the pelvic cavity by the quick attention of one of the assistants compressing the lips of the wound around the stump. I then tied a double transfixated silk ligature around the pedicle, and after all hemorrhage had stopped, the abdomen was very carefully cleaned of what little blood could be found; the pedicle returned into the abdomen; the wound closed with four deep seated double well carbolized silk ligatures and two oiled pasteboard strips, used in the manner of a quilted suture, thereby bringing the internal surfaces of the peritoneum together in apposition; about eight superficial sutures were next introduced to close the wound completely; the wound measured three and one-half inches after closing; dressed with carbolized glycerine and lint, covered with prepared cotton; a bandage of gauze finished the dressings; the hoops fixed to the bed and patient covered with blankets; one-fifth grain of morphine subcutaneously injected into the arm; lost about one ounce of blood in all. The vomiting was very troublesome and obstinate during the operation. The operation had to be suspended several times on account of it, thereby causing considerable delay; at one time it was so severe that it took the hands of three assistants to support the abdomen firmly to prevent the escapement of the viscera; the occurrence of this unfavorable symptom was much regretted by all present. The operation lasted two hours from the beginning of the preparation until the patient was dressed. Before the operation: Pulse, 80; respiration, 40; after the operation: Pulse, 120; temperature, 99.2°; respiration, 36.

3 p. m.—Administered opium gr. i, followed shortly after by vomiting; ice given at intervals.

6 p. m.—Pulse, 122; respiration, 23; vomited; ice; oxalate cerium gr. i.

9:30 p. m.—Vomited once severely; ice; slept 50 minutes; ice; slept again until 11 o'clock; ice; vomited.

Oct. 16th, 2 a. m.—One-fifth grain of morphine subcutaneously over epigastric region; slept till half past 5 o'clock; pulse, 100; temperature, 100°; no vomiting; passed urine twice naturally.

10 a. m.—Pulse, 120; passed urine again; vomited; ice, beef tea, milk.

2:30 p. m.—One-tenth grain morphine; quiet.

6 p. m.—One-fifth grain morphine; pulse, 130.

7 p. m.—Pulse, 120; respiration, 27.

8:30 p. m.—Pulse, 132; respiration, 28; awake. 9 p. m.—Pulse, 125; respiration, 27; asleep.

12 p. m.—Pulse, 98 while asleep.

Oct. 17th, 6 a. m.—Pulse, 111; temperature, 99°; respiration, 28; awake; passed urine.

7:30 a. m.—One-fifth grain morphine; pulse, 125; fore part of night quiet, after part restless.

12 m.—Pulse, 110; temperature, 99°; respiration, 24; vomited; gr. i oxalate cerium; ice, milk.

6:30 p. m.—Pulse, 135; respiration, 27.

9:30 p. m.—One-fifth grain morphine.

10:30 p. m.—Pulse, 102; asleep; feels weak; beef tea and brandy, 1 ounce, per rectum.

Oct. 18th, a. m.—Beef tea and brandy per rectum; a little nauseated; gr. i oxalate cerium; ice; slept all night tranquilly.

5:30 a. m.—Pulse, 124; respiration, 24; awake.

6 a. m.—Pulse, 102; respiration, 21; awake.

7 a. m.—Dressed wound in presence of Dr. Thos. O'Reilly; it looked well; no pus whatever; healed by first intention; no peritonitis; no tympanitis except over the region of the stomach when full with fluid; thought some of the stitches could be removed next day; pulse, 120; $\frac{1}{2}$ gr. morphine; sleeps.

12 m.—Pulse, 120; temperature, 100°; respiration, 20.

2 p. m.—Beef tea and quinine per rectum; vomited; patient became irritable and peevish; no change up to 4:30 p. m. when I left her for a short time, returning at 7:30 o'clock; I was informed that she had become worse; the priest had been sent for, also the family physician, and that she was now unconscious; pulse, 158; respiration, 20, and spasmodic; administered 1 oz. of brandy and milk per rectum; repeated it again an hour later; warm water bottles to feet; she revived enough to recognize her parents; swallowing difficult.

10:30 p. m.—Respiration, 11; spasmodic; she gradually sank and expired at 1:30 a. m., October 19.

I will state that I operated under the carbolic acid spray. A battery was held in readiness, but not needed. The temperature of the room during operation was 80° F., and was kept at about 70° afterwards. A window was also kept partly open in adjoining room, and the steam atomizer occasionally used to keep the air moist. One-quarter gr. of morphine in granules was tried twice internally, but ejected; afterwards the morphine was always sub-cutaneously administered over the epigastric region; milk, beef tea, gruel and ice cream could not be retained; brandy and water sometimes. After vomiting, the patient always felt relief, but the craving for water and ice was intense, so that she had to be restrained. She would remain quiet until the stomach was again filled with fluid, bloated up and distended; after vomiting, the stomach would collapse. About one-half hour before death, her stomach being full, a gurgling noise was heard; the fluid seemed to escape into the intestine; no power to vomit.

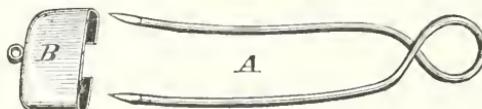
Previous, during the act of vomiting, she would support her abdomen herself with both hands, and often requested me to lay my hands over the stomach and make a gentle pressure, which was agreeable to her. She was a good, sensible and obedient patient. I remained at the house every night and the greater part of the day, being relieved in the morning and afternoon, a short time alternately, by Drs. Diggens and Vogt, to whom I am especially indebted for the care bestowed upon the patient during my absence, and to the family physician for the interest he took in the case, as well as to the other gentlemen and the sister, who admirably and faithfully performed her duty. All the directions were minutely carried out by all the members of the family, for which they deserve great credit.

About six gallons of fluid were drawn from the cyst; clear, like water; specific gravity not quite 1004; contained slight traces of albumen; very slightly acid; cyst itself weighed three and one-half pounds. Microscopic examination not satisfactory; the fluid had spoiled before I had time to examine it; no post mortem.

Ovariotomy has been performed a number of times during the past ten years by different surgeons in this city. It would be both instructive and interesting, as well as a valuable contribution towards the statistics, if correct reports of all these cases and their results were at hand.

Annexed is a description of the cyst elevator which I use:

Fig. 1.



A, the elevator. *B*, a cap to protect the points.

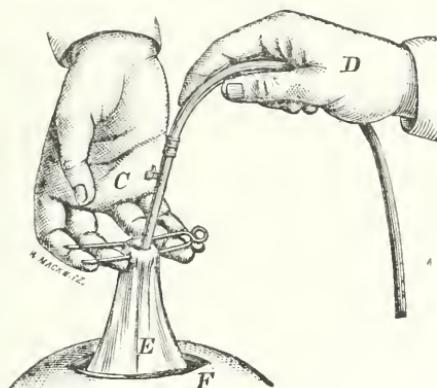
This is a simple instrument made of strong steel wire, shaped like a tuning fork, slightly curved, representing a double needle.

Fig. 2. See fig. 1, *A*, half size. This is thrust into the cyst after opening the abdomen, linear as shown in Fig. 2. It is then handed to the first assistant, who holds it upon the fingers of his right hand, as shown in Fig. 3. The trocar is introduced by the operator perpendicularly down into the cyst, and between the prongs of the elevator and the fingers.

The advantage of this method is: no fluid can escape from the cyst, and as the sac empties itself it is gently and very slowly drawn out by the assistant; the trocar is pushed gently deeper at the same time, the abdominal walls collapsing around the cyst, which are supported by the hands of another assistant, thus pre-

venting any of the viscera from protruding, and by the time the cyst is nearly empty it is also almost drawn out from its bed, the hold is firm, and necessary traction and manipulating is avoided,

Fig. 3.



C, right hand of assistant. *E*, the Cyst.
D, right hand of operator. *F*, abdomen.

and no air can enter; if needed, a ligature can be applied around the cyst and trocar below the prongs of the elevator; with a little care all soiling of clothes and bedding can be prevented.

A full description of all the instruments that I employ, *and which should not be used for any other purpose*, can be obtained in pamphlet form from A. M. Leslie & Co., St. Louis, Mo.

Directions for patient, always to be given in writing: The best room in the house is always to be selected. All furniture, carpets, curtains, etc., are to be removed; the room is to be freshly whitewashed, floor and woodwork well scrubbed with soap and water, and rinsed with water and chlorinated soda, one to two tumblersfuls to a bucketful of soft water. Procure a small, new bed-lounge six feet long and twenty-eight inches broad, with two square blocks of wood six inches high, or more, with holes drilled into them to receive the rollers of the feet of the bed, to make it stand solid and firm, and to elevate the bed to a proper height to suit the operator, and a good firm mattress to fit the bed must be nine or ten inches high; two small tables; one chair; two yards of Indian rubber or oil cloth to spread over the bed; one-half dozen soft towels, three or four stone wash-bowls, and one pitcher; one thermometer; one clean bucket for water, and one cup; one old bucket or tub; tumblers, drinking water, tea spoon; three or four wooden clean hoops, and bed-pan. The towels, as well as the bed clothes and dresses, must be well washed and rinsed in the solution of chlorinated soda; must not be tarched. During the operation no one is allowed to leave or

enter the room, and after the operation, under no circumstance is any person permitted to visit the patient or remain in the room, excepting the nurse or the attending physician.

The following are the directions for the druggist:

B.	Distilled Water.....	.5 gallons.
	Oil Silk.....	1 yard.
	Lister's Carbolized Gauze, (for bandage).....	1 piece.
	Alcohol.....	1 pint.
	Liq. Ferri, Persulphatis.....	$\frac{1}{2}$ ounce.
	Brandy (French).....	1 pint.
	Chloroform and Sulph. Ether } aa.....	1 pound.
	(Squibb's or Malinkrodt's best)	
	Carbolized Acid, pure.....	1 ounce.
B.	Iodine.....	grs. ii.
	Pot. Iod.....	$\frac{3}{3}$ ss.
	Aqua Dist.....	$\frac{3}{3}$ viii. M.

Sig. Used to fumigate the room before operation.

B.	Acid Carbolic.....	$\frac{3}{3}$ i.
	Glycerine.....	$\frac{3}{3}$ vii. M.

Sig. Used to mix with water to wash the hands, instruments and sponges; the latter should be new, and of the finest quality; previously well washed in a weak solution of nitric acid, then kept in a solution of carbolic acid.

B.	Acid Carbolic.....	$\frac{3}{3}$ i.
	Glycerine.....	$\frac{3}{3}$ iv. M.

Sig. Used for dressing the wound.

B.	Acid Carbolic.....	$\frac{3}{3}$ i.
	Ol. Olive.....	$\frac{3}{3}$ vi. M.

Sig. Used to pour upon a saucer or plate: the ligatures and threaded needles are laid and kept in this until needed.

B.	Chloride Sodium.....	$\frac{3}{3}$ iv.
	Albumen.....	$\frac{3}{3}$ vi.
	Dist. Water.....	O i. M.

Sig. Used for dipping the hands, instruments and sponges in after disinfection, and before using them (this is the artificial serum), and has to be diluted with three parts of warm water, the temperature of blood heat.

B.	Opii Pulv.....	} aa gr. xii.
	Sacc. Alb.....	}

Misce. et div. in Chart. No. I2. Sig. Used as directed.

B.	Acid Carbolic.....	} aa $\frac{3}{3}$ i.
	Alcohol.....	
	Glycerine.....	
	Aqua Dist.....	$\frac{3}{3}$ v. M.

Sig. This has to be diluted with three parts of water, and used for the steam atomizer as a spray during operation.

3613 N. Ninth St.

FRACTURE OF THE HUMERUS BY MUSCULAR EFFORT. By DAVID PRINCE, M. D., of Jacksonville, Ill.

It is not often that one has the opportunity of standing by while a bone is broken by the unaided contraction of the muscles attached to it.

A patient, 58 years old, who had syphilis twenty-five years before, was sitting in Holmes' invalid or operating chair (such as is figured in Sims' Uterine Surgery), for the purpose of having a bougie inserted for the dilatation of a stricture of the urethra. The patient, with his hands grasping the arms of the chair, was giving tension to his muscles, when a snap occurred, and he asked, "What is that?" The humerus was seen to bend forward above the origin of the supinator radii longus, and the question was answered.

The contraction of this muscle and that of the extensor carpi radialis longior, while the bone was firmly fixed by other muscles, was undoubtedly the chief cause of the fracture.

The general health of the patient was good, and that particular bone had never been broken before, though many years before he had fracture of other bones.

VERSION AFTER FIVE DAY'S LABOR—TETANUS UTERI. By CARL WALLISER, M. D., of Highland, Ill.

On the 19th of July, 1876, I was called to attend Mrs. N—, who was confined with her fourth child. The woman had the first pains in the morning of the 15th; the membranes ruptured soon after; from that time she had very strong pains, of long duration, with short, and at last, no intervals. On the evening of the 18th, two physicians tried the internal version during chloroform narcosis. They failed on account of the rigid os, which did not permit the introduction of the hand into the uterus. Shortly after this unsuccessful operation, an arm prolapsed; the child's movements then ceased to be felt. This is the history given to me by the midwife at my arrival.

On examination, I found the patient in a collapsed condition; pulse and respiration weak; pressure on the abdomen very painful; the uterus hard like a bone. From external exploration I was not able to diagnose the position of the child. In

the swollen and sensitive vagina was an arm, which was constricted above the elbow by the os, so that I could not enter two fingers between the arm and os in order to dilate.

As I was informed that chloroform had been administered twice, I made a sub-eutaneous injection of $\frac{1}{2}$ gr of morph. mur. No appearance of dilatation being visible, I ordered, 20 minutes after, a tablespoonful of this medicine :

R—Chloral hydrate.....	8, ʒij.
Aqua.....	45, ʒiv.
Syr. Currant.	15, ʒv.

Fifteen minutes after, the pains diminished gradually, and still 15 minutes later, after a second dose, the os dilated slowly; I ordered one dose more, when the patient fell asleep. I then introduced the whole hand into the relaxed uterus, and found the left shoulder advanced in the exitus pelvis; the arm replaced, I succeeded in seizing the one, and soon after, the other, foot. The version being performed, a dead child was easily delivered; placenta expelled by Crédi's method. The mother recovered in due time.

Soon after, the family moved in the vicinity of Summerfield, Ill., and I heard nothing more of them till this spring, when I met Mr. N——, who told me that three weeks ago his wife had been again confined, and had died after an operation performed, after some days of labor, by the physicians of her place.

Periscope of Current Medical and Scientific Literature.

SURGERY.

THE DIAGNOSIS AND TREATMENT OF INTESTINAL OBSTRUCTIONS.—The importance of the deductions determined by Jonathan Hutchinson in a recent paper read before the British Medical Association on the "Diagnosis and Treatment of Intestinal Obstructions," make their careful consideration an imperative duty with every physician and surgeon, and justify the presentation in full of his memoranda for diagnosis and treatment, which we find extracted from the *British Medical Journal*, August 31, 1878, by the *American Journal of Medical Sciences* for October, 1878:

Memoranda for Diagnosis.—1. When a child becomes suddenly the subject of symptoms of bowel obstruction, it is probably either intussusception or peritonitis.

2. When an elderly person is the patient, the diagnosis will generally rest between impaction of intestinal contents and malignant disease, (stricture or tumor).

3. In middle age, the causes of obstruction may be various; but intussusception and malignant disease, both of them common at the extremes, are now very unusual.

4. Intussusception cases may be known by the frequent straining, the passage of blood and mucus, the incompleteness of the constipation, and the discovery of a sausage-like tumor, either by examination *per anum* or through the abdominal walls.

5. In intussusception, the parietes usually remain lax, and, there being but little tympanites, it is almost always possible, without much difficulty, to discover the lump (or sausage-like tumor) by manipulation under ether.

6. Malignant stricture may be suspected when, in an old person, continued abdominal uneasiness and repeated attacks of temporary constipation have preceded the illness. It is to be noted, also, that the constipation is often not complete.

7. If a tumor be present and pressing on the bowel, it ought to be discoverable by palpation, under ether, through the abdominal walls or by examination by the anus or vagina, great care being taken not to be misled by scybalous masses.

8. If repeated attacks of dangerous obstruction have occurred with long intervals of perfect health, it may be suspected that the patient is the subject of a congenital diverticulum, or has bands of adhesion, or that some part of the intestine is pouched and liable to twist.

9. If, in the early part of a case, the abdomen become distended and hard, it is almost certain that there is peritonitis.

10. If the intestines continue to roll about visibly, it is almost certain that there is no peritonitis. This symptom occurs chiefly in emaciated subjects, with obstruction in the colon of long duration.

11. The tendency to vomit will usually be relative with three conditions and proportionate to them. These are (1) the nearness of the impediment to the stomach, (2) the tightness of the constriction, and (3) the persistence or otherwise with which food and medicine have been given by the mouth.

12. In cases of obstruction in the colon or rectum, sickness is often wholly absent.

13. Violent wretching and bile-vomiting are often more troublesome in cases of gall-stones or renal calculus simulating obstruction than in true conditions of the latter.

14. Fecal vomiting can only occur when the obstruction is moderately low down. If it happen early in the case, it is a most serious symptom, as implying tightness of constriction.

15. The introduction of the hand into the rectum, as recommended by Simon of Heidelberg, may often furnish useful information.

Memoranda for Treatment.—1. In all early stages, and in all acute bases, abstain entirely from giving either food or medicine by the mouth.

2. Use anaesthetics promptly. Put the patient under the full influence of ether; examine the abdomen and rectum carefully before tympanites has concealed the conditions; administer large enemata in the inverted condition of body; and, if advisable, practice abdominal taxis. If you do not succeed at first, do it repeatedly.

3. Copious enemata, aided perhaps by the long tube, are advisable in almost all cases, and in most should be frequently repeated.

4. Fluid injections may be sometimes replaced by insufflation of air in cases of invaginations, since air finds its way upwards better, and is more easily retained. It is, however, somewhat dangerous, and has, perhaps, no advantages over injections with the trunk inverted.

5. Insufflation is to be avoided in all cases of suspected stricture, since the air may be forced above the stricture, and there retained.

6. Saline laxatives are admissible in certain cases where impaction of the feces is suspected, and in cases of stricture where fluidity of feces is advisable.

7. Opium (or morphia) must be used in proportion to the pain which the patient suffers. It should be administered by the rectum or hypodermically, and should be combined with belladonna. If there be not much pain or shock, it is better avoided, since it increases constipation and may mask the symptoms.

8. A full dose of opium administered hypodermically will put

a patient in a favorable condition for bearing a prolonged examination under ether, and attempts at abdominal taxis.

9. In cases of uncertain diagnosis, it is better to trust to the chance of spontaneous cure of relief by repeated abdominal taxis, than to resort to exploratory operation; or, in desperate cases, iliac enterotomy should be done. Operations for the formation of an artificial anus in the right or left loin may be performed whenever the diagnosis of incurable obstructive disease in the lower bowel is made.

10. The operation for the formation of an artificial anus through the anterior part of the abdominal wall and into the small intestine should be resorted to only in certain cases of insuperable obstruction, in which the seat of disease is believed to be above the cæcum.

11. In all cases in which the precise seat of disease is doubtful, but the large intestine is suspected, the *right* loin should be preferred. If the colon here be found to be empty, the peritoneum may be cautiously opened and a coil of distended small intestine brought into the wound.

12. My last suggestion as to treatment is one which, speaking as I do in a Medical Section, I feel some delicacy in making. It is, however, I believe, a very important one, and it is this, that cases of mechanical obstruction are really surgical and not medical cases. They require manipulative measures both for diagnosis and for treatment, and they require them early. It is difficult to explain why it has come about that, as a rule, a physician is called in first, and nothing but drug treatment usually adopted in the early periods; and it is, I am convinced, much to be regretted. The surgeon is but too often asked to see the case only in the last stage, when it is thought that perhaps an operation may be desirable. At this period the abdomen is distended, and an accurate diagnosis impracticable; but, what is worse, the stage at which abdominal taxis is most hopeful has passed. My remarks do not, of course, apply when the medical attendant possesses the knowledge and exercises the functions of both branches.

Dr. Bull in his report on Surgery, in the *New York Medical Journal*, says: In the *Ohio Medical and Surgical Journal* for June, 1878, Dr. R. F. Weir gives the result of the use of thymol dressing, at the Roosevelt and New York Hospitals, as follows: "The thymol dressing has now been tested in twenty-five cases, as follows—amputations (thigh and leg), 5; compound fractures (thigh and leg), 3; lacerated wounds (leg and foot), 6; abscesses, 3; removal of bone for necrosis, 3; lumbo colotomy, 1; amputation, fingers, 3; removal tumor, 1—with the result of eleven successes and fourteen failures. By failure is meant that an aseptic condition was not preserved. The explanation given for such a failure, when first resorting to Listeric method—*i. e.*, a too limited experience in its application, does not hold in connec-

tion with Rankis dressing, for the house-staff were thoroughly trained in its use, and every detail was carefully carried out. The failures were not only characterized by the usual appearance of odor, etc., but even in the successful cases, that is, where the wounds were progressing satisfactorily, it was noticed that there was greater elevation of the temperature and more frequent appearance of acute edema than are met with in the carbolized dressings."

"The macintosh used in lieu of the gutta-percha tissue or parchment paper, suggested by Ranke, suffered from the action of this thymol, and soon became unfit for use, and oftentimes a greenish color was imparted to the skin next the wound."

"A further test would have been sought for before publication, but these results have been so decidedly confirmed by the reports received this week from the surgeons assembled at the recent meeting of the Surgical Congress, at Berlin, that it was not deemed worth while to delay further in order to present an increased number of cases. In the congress, held in April of this year, Dr. Küster, of Berlin, Olshausen, of Halle, Schede and Langenbeck, Berlin, spoke of the uncertain results obtained by thymol. Bardeleben, (Berlin) objected to it, not only because it did not possess the antiseptic qualities of the five-per-cent carbolic acid solution, but also because the sweet odor of the thymol produced headache and attracted swarms of flies.

CAUSE OF DEATH AFTER BURNS.—In a communication read before the meeting of the Association of German Naturalists and Physicians (*Berliner Klin. Wochenschrift*, No. 46, 1877,) Dr. Ponfick gave the results of a series of experiments made by himself and F. Schmidt with reference to the results of severe burns. The blood was found to be altered in cases of severity, the red corpuscles separating into numerous small bits. These disappeared after a varying number of hours, with the seeming effect of exciting grave disturbance in several organs. A large portion of the apparently free haemoglobin was eliminated through the kidneys, the parenchyma of which in the severe cases was evidently much inflamed, peculiarly colored casts being found in the urine, while the tubules were obstructed and the epithelium in a state of fatty degeneration. Another portion of the decomposed red corpuscles was taken up by the contractile cells of the spleen and bone-marrow, in which a gradual destruction was probably accomplished. The enlargement of these parts, their increased redness and moisture, appeared to indicate that the change mentioned was present.

Dr. Ponfick believes it probable that some of the rapidly fatal cases, and some of the severe symptoms in cases of recovery result from the extensive and sudden destruction of red blood-corpuscles. The rapid suppression of urine, and a resulting uraemic poisoning, may also be of importance. From the evidence presented by these experiments, Ponfick recommends transfusion as

a rational therapeutical measure in cases of severe burns.—*London Med. Record*, July 15, 1878.

OPERATIONS ON THE INVERTED HEAD.—Dr. J. C. Warren, M. D., in the *Boston Med. and Surg. Jour.*, says: Dr. Julius Wolff, in a late number of Volkmann's lectures, gives an interesting account of his experiments with this method of avoiding the flowing of blood into the trachea. It was invented, he says, by Rose, and consists in placing the patient on his back during anaesthesia, and allowing the head to hang at right angles with the body over the end of the table. The danger of operating upon the throat and jaws in the erect posture we well know. Profound anaesthesia renders the air passages insensible to the presence of blood, and it requires but a moderate amount to interfere seriously with respiration. The writer suggests that blood may not only flow, but may even be drawn into the trachea by a deep inspiration, and also mentions cases when an amount of blood not sufficient to produce dangerous symptoms during the operation caused subsequently fatal bronchitis and pneumonia. The amount of blood swallowed is thought sometimes to bring on fatal disturbances of the digestive apparatus, as occurred apparently in one of the author's cases. To avoid these occurrences it is necessary in certain cases to insert a tracheotomy tube and plug the pharynx,—a very serious addition to any operation. On the other hand, with the head in the inverted position the blood flows readily from the mouth and nostrils into a basin below, and respiration goes on unimpeded. The head is in a convenient position for operating, and the mouth is much more easily illuminated and approached than in the usual position. Dr. Wolff employs this method in a large number of operations, including not only those in the mouth but on the lips and face; also in tracheotomy, for which the position of the neck is particularly favorable, the trachea being drawn out much further from the thorax, and the soft parts being made more tense over it than in the usual position. So far from being dangerous during the action of chloroform, it is supposed to offset the tendency to anaemia of the brain caused by that drug. The disadvantages of the method are: the extra amount of bleeding caused by the dependent position; but this is not much greater than ordinarily occurs. To offset the disadvantage of extra hemorrhage in excision of the upper jaw, Volkmann separates the cheek from the jaw, and cuts through the malar and nasal processes while the patient is upright; then changes the position and cuts through the gums and palate. Dr. Wolff has performed a number of operations for the relief of cleft palate in the inverted position, and finds it far superior to any other.

Mr. Hutchinson submitted, as a most important proposition, that, in the present state of surgical knowledge, exploratory operations for the relief of abdominal obstruction, the cause of which cannot be diagnosed, are not unwarrantable. Operations performed at the hernial regions, in search, it may be, for sus-

pected *reduction en masse*, are, of course, quite outside this rule. It refers only to opening the abdomen in the middle, with the intent to introduce the hand and search for the obstructed part.

If, however, we turn to certain cases in which the precise cause of obstruction is definitely diagnosed, then a different decision must be arrived at. In cases of invagination, when the included tract is long and when other measures have been exhausted, abdominal section is probably the best method of treatment. Here the surgeon knows what he is going to attempt, and that in the majority of cases it can easily be accomplished. The operation is justifiable at a comparatively early stage, when there is not much risk of rupture of the bowel, and but little difficulty may be expected in getting the contents back into the abdomen. Yet even here the operator encounters the discouragement of knowing that nature is competent to the cure by sphacelus of some of the most desperate forms of intussusception, and it is not yet settled whether leaving them to this chance involves less or more risk than operating. My own opinion is, however, definite; and in any such case, enemata, insufflation, and other measures having had patient and repeated trials, I should not hesitate to open the abdomen. I have done this in two cases, and in one of them with perfect success; and successful cases have also been recorded by Mr. Howard Marsh, Mr. Howse, and other surgeons. In the peculiar form of intussusception beginning at the cæcum and advancing until the inverted ileo-caecal valve presents at the child's anus, I should suspect that an operation will always be required, for I know of no reliable record of the recovery of such a case either by gangrene or by the measures to which we may apply the name of rectal taxis.

H. H. M.

GYNAECOLOGY.

VAGINAL SUPPOSITORIES—The *Cincinnati Lancet and Clinic* says they are made by melting the ingredients together and pouring them into moulds to solidify. A good vehicle is a mixture of water, gelatine and glycerine. The proportion is one part of gelatine to six parts of glycerine, which may require modification according to the concentration of the respective ingredients. Almost all substances may be incorporated except tannin.

CHRONIC CERVICAL METRETIS—Dr. Jas. M. Bennet, surgeon to the Liverpool Surgical Home, describes in the *Dublin Journal of Medical Science*, his method of treating the above mentioned disease, which consists in the hypodermic injection of cervix with iodine. The solution used, is a compound of a solution contain-

ing ten grains each of the iodide and bromide of potassium, to which a half drachm of the tincture of iodine and sufficient distilled water is added to bring it up to two drachms. He uses a modification of an ordinary hypodermic syringe, with a needle sufficiently long to be used through a speculum, and these points are made of 18 carat gold, to resist the chemical action of the substance injected. Three to five punctures are made according to the amount of hyperplastic matter to be absorbed; cotton saturated with glycerine is placed against the vaginal cervix, and rest is enforced for twelve hours. He seldom finds more than three operations necessary; has never known it to cause any general or local disturbance of movement; but on the contrary has thus effected many cures, after other methods had failed. In most cases he combines this treatment with dilation by means of sponge tents, which is practiced after the first effects of the dilation has passed off.

ON RETENTION OF THE URINE IN THE FEMALE—Dr. J. H. Croom ends an article in the *Edinburgh Medical Journal*, on this subject, as follows:

It would thus appear that the causes leading to retention of urine in the female may be thus conveniently grouped:

1. Injuries or contusions during labor, acting directly or by subsequent inflammations.
2. Pressure of displacements or tumors acting mechanically on urethra or neck of the bladder.
3. Injuries or growths acting reflexly.
4. Diseases of the nervous system.
5. Direct obstruction within the tube of the urethra, as from stricture or foreign bodies, such as a calculus.

In drawing this paper to a conclusion there are one or two points which seem worthy of note.

1. In all cases of retention of urine a vaginal examination is necessary.
2. A gum-elastic male catheter of medium size, without the stilette, is the best form of instrument to employ.
3. In retention from displacement it is important to remember the altered position of the urethra. In retroversion of the gravid uterus the vagina is drawn upward and forward, the meatus is drawn upward, and the direction of the upper part of the canal is backward and downward.
4. When any difficulty exists in accounting for the retention, a visual examination should be insisted on.
5. It is a safe rule, before giving a definite verdict on any pelvi-abdominal tumor, to empty the bladder. W. L. B.

Editorial.

WITH this number of the JOURNAL we close the year of 1878, and the second volume issued under our control (the thirty-fifth). We are pleased to have been *frequently* informed by our subscribers that we have performed *all* of the promises that we made at the time we took charge of the JOURNAL. On assuming control of the JOURNAL, we determined that it should, ere long, rank second to no journal in the West in point of usefulness and circulation. We now look back with great satisfaction to the success that has attended our efforts in these directions. Its circulation has been so greatly extended that it has given us an opportunity to increase its size, so that it is now equal in size to that of the largest medical monthly.

While we claim that we have to some extent increased the usefulness of each issue, we are conscious that it can be much improved; with this end in view we have connected with ourselves a very large corps of collaborators, each one of whom has entered into work with an *undivided* determination to raise the JOURNAL to the highest rank of usefulness. We flatter ourselves that no one can read our prospectus without being struck with the strength displayed in the large list of reporters and contributors. No medical journal in the West has ever been able to surround itself with such an array of medical talent.

2,000.

This will be the *bona fide* circulation of the JOURNAL beginning with the January issue. With this number we will commence the official publication of the proceedings of the Tri-State and Linton District Medical Societies. This distinctive feature of the JOURNAL will give to it a prestige which cannot fail to enhance its value. We assert without fear of successful contradiction that no medical journal in the West has ever increased with a like rapidity.

Books Notices and Reviews.

THE USE OF SOLID RUBBER BANDAGE IN TREATMENT OF ECZEMA AND ULCERS OF THE LEG. By S. DUNCAN BULKLEY, A. M., M. D., of New York.

This is an instructive pamphlet, and though the author does not claim anything original, he modestly gives all the credit to Dr. Martin. For this reason the profession is the more indebted to him for publishing his cases. As his field for observation is so extensive, we hope to hear from him again upon this subject, and thereby help to encourage the treatment with the rubber bandage. This method is so simple and so efficacious that it is endorsed by all who have employed it. We recommend the book to the profession.

E. B.

The Physician's Pocket Day Book. By C. HENRI LEONARD, M. D. Accommodates daily charges for twenty or forty families weekly, has complete obstetrical record for ninety-four cases, and monthly memoranda for Dr. and Cr. cash accounts. (For sale by the St. Louis Book and News Co.)

The Physicians Visiting List for 1879 (twenty-eighth year of its publication). Philadelphia, Lindsay & Blakiston.

News and Items.

We have received from Wm. Wood & Co., of New York, a copy of "Rest and Pain," by Hilton, which is to be the January volume of "Wood's Library of Standard Medical Authors." The get-up of the book is in every respect equal with the high-priced editions now being sold. As we look at it, and consider its price of \$1.00, it is a marvel even to us. Of course it can only be sustained by the practical appreciation of many, many thousands of the profession.

To meet the views of all classes, the publishers have concluded to take subscriptions: First, the \$12.00, payable on delivery of the first volume, in which case the volumes are all delivered free, by mail, from New York; second, payable \$6.00 semi-annually, in January and July, in which case the subscriber pays express charges on January, and on the July volumes, the other volumes being sent free by mail; and third, payable monthly at \$1.25 per volume; in this case the volumes are each delivered free, by express or carrier, C. O. D.

METEOROLOGICAL OBSERVATIONS.

By A. WISLIZENUS, M. D.

The following observations of daily temperature in St. Louis are made with a MAXIMUM and MINIMUM thermometer (of Green, N. Y.). The daily minimum occurs generally in the night, the maximum at p. m. The monthly mean of the daily minima and maxima added and divided by 2, gives quite a reliable mean of the monthly temperature.

THERMOMETER, FAHRENHEIT—OCTOBER, 1878.

Day of Month	Minimum.	Maximum.	Day of Month.	Minimum.	Maximum.
1	60.0	84.5	18	39.5	53.0
2	57.5	78.5	19	37.5	59.5
3	58.0	80.5	20	43.5	72.0
4	62.5	69.0	21	50.0	65.0
5	52.5	58.0	22	40.0	53.0
6	46.0	66.5	23	40.0	68.0
7	54.0	73.0	24	45.5	66.5
8	55.5	81.0	25	49.5	54.0
9	63.0	72.5	26	38.0	43.5
10	62.0	75.0	27	32.5	40.5
11	58.0	68.5	28	30.0	47.5
12	36.5	70.5	29	32.5	46.0
13	50.0	73.5	30	38.0	51.5
14	61.0	\$7.0	31	27.0	41.0
15	66.0	82.5	Means		57.1
16	72.5	80.0	Monthly Mean		65.1
17	45.0	60.0			

Quantity of rain, 3.11 inches.

MORTALITY REPORT---CITY OF ST. LOUIS.

FROM SEPT. 29, 1878, TO OCT. 26, 1878, INCLUSIVE.

Yellow Fever.....	Cholera Infantum.	3 Hydrocephalus and	Apoaplexy	7
Measles	Inanition, Want of	Tubercular Men-	Cyanosis and At-	
Syphilis, Cong'pal.	Breast Milk, etc.	ingitis	electasis	5
Scarlatina	2 Alcoholism.....	6 Meningitis and En-	Premature and Pre-	
Pyæmia	1 Rheumatism and	cephalitis.....	termatural Birth..	9
Erysipelas.....	Gout.....	Direct Effect of So-	Surgical Operat'ns.	
Diphtheria	21 Cancer	lar Heat	Deaths by Suicide..	3
Membranous-Croup	13 Phthisis Pulmon.	52 All Diseases of the	Deaths by Accid'nt.	13
Whooping Cough	3 Bronchitis.....	5 Brain and Nerv-		
Typhus Fever.....	1 Pleuritis.....	ous System	Total Deaths from	
Typhoid Fever	7 Septicamia	26 Cirrhosis of Liver	all Causes.....	410
Cerebro-Spinal Fe.	2 Pneumonia	13 and Hepatitis	Total Zymotic Dis-	
Remittent, Inter-	Heart Diseases	16 Enteritis, Gastro-	eases.....	158
mittent, Typho-	Other Diseases of	Enteritis, Peri-	Total Constitution-	
Malaria, Con-	Respir'ty Organs	tonitis, and Gas-	al Diseases.....	84
gestive and Sim- ple Continued Fever.....	4 Enterico-Colitis	titis.....	Total Local Dis-	
Puerperal Disease's	Marasmus—Tabes	15 Bright's Disease	eases.....	147
Diarrhoeal	Scrofula	and Nephritis	Total Develop'tal	
4	21 Convulsions	21 Other Diseases of	Diseases.....	15
14	23 Urinary Organs	23 Urinary Organs	2 Deaths by Viol'ce.	16

CHAS. W. FRANCIS, Health Commissioner.

COMPARATIVE MORTALITY RATES.

CITIES.	Estimated Population, July, 1878.	Total Mortality for four weeks, ending Sept. 29, 1878.	Annual Death Rate per 1000 for the four weeks.
New York.....	1,093,171	1,949	23.22
Philadelphia	876,118	1,134	16.93
Brooklyn	549,438	910	21.53
St. Louis.....	500,000*	576	13.92
Chicago	460,000	641	18.76
Boston.....	375,476	588	21.00

*Estimated population, May 1, 1877, 501,489.

THE BEST IN THE MARKET.

PARKE, DAVIS & CO.'S

IMPROVED

EMPTY CAPSULES.

Our Capsules are manufactured by means of improved apparatus, producing the most accurate and unvarying results. The gelatine employed is of the finest quality, which, in our hands, undergoes a certain process, increasing its transparency and elasticity. Through these improvements in apparatus and material, we are enabled to produce capsules which are uniformly accurate, transparent, elastic and permanent, in which properties they are *excelled by none sold in the United States or Europe.*

These little articles will be found of great value and convenience in the hands of the physician who studies to remove the objectionable properties of the medicines which he deems it necessary to employ.

Many drugs, among which we may note *roots, gums, emetics, capsicum, etc.*, which—either from the more immediate effect to be produced, or from some special action to be desired—the physician proposes to administer in the *crude* or *powdered* state, in preference to any form of preparation, are practically debarred from use in certain cases on account of their properties (appearance, odor, taste), and the difficulty experienced in swallowing them. It is frequently advisable to conceal from the patient the nature or identity of the drug, because of some *idiosyncasy*, or of his imagination with regard to its peculiar effects on his system.

To be able to easily disguise these features of a remedy at the bedside of a patient, at a time and place when he cannot employ the assistance of a pharmacist, is a great desideratum to the practitioner.

Our Capsules will fully supply this want; a few trials will demonstrate all their advantages, among which we may enumerate the following:

Convenience.—A box (100 capsules) can be carried in the pocket without inconvenience, ready for use as desired. They may be filled with the medicine in a moment, thoroughly disguising its appearance, odor and taste, and are easily swallowed, thus gaining, if we may use the phrase, a foothold in the stomach for the drug, which would have been quickly rejected by the patient in its undisguised state.

Solubility.—We have endeavored to so prepare our gelatine that it will quickly dissolve under the combined action of the warmth and moisture of the stomach, requiring but little digestive action, and as a result, *our capsules can be employed in dyspepsia and other forms of irritable or torpid stomach*, when this property is essential.

Therapeutical Effect.—The gelatine having become dissolved, the remedy is brought into contact with the surface of the stomach *under the most favorable circumstances*, and, if the case will permit, will soon be assimilated, and the desired results achieved.

Emetics. are exhibited in capsules to great advantage, and quick returns may be confidently expected. In this respect capsules are in contrast to pills, which, from their form and constituents, gradually dissolve in the stomach, producing the effects desired from narcotics, tonics, etc., while they are not dissolved rapidly enough for the use to which powerful emetics are devoted.

Administration.—Capsules, can, of course, be applied to the administration of any class of medicines, either simple or in combination; yet they are especially designed for facilitating the act of swallowing such articles as *powdered roots and gums* (which, from their insoluble or glutinous nature, are liable to linger in the mouth too long), or for disguising the taste of *quinine, morphine, capsicum, oils, fluids and solid extracts, etc.*

Our Capsules are put up in neat sliding paper boxes, containing 100 each, for which we charge fifty cents each. We will mail a box to any address on receipt of the price and three cents postage.

Parke, Davis & Co.,

Send stamps for a sample

DETROIT, MICH.

Trommer's Extract of Malt.

The rapidly increasing demand for our IMPROVED EXTRACT OF MALT, during the four years that it has been manufactured and offered to the medical profession in America, justifies the belief that in its production here we are meeting a generally felt want.

Long experience in manufacturing Malt Extract has enabled us to completely overcome the many difficulties attending its manufacture in large quantity; and we positively assure the profession that our Extract of Malt is not only perfectly pure and reliable, but that it will keep for years, in any climate, without fermenting or molding, and that its flavor actually improves by age. Our Extract is guaranteed to equal, in every respect, the best German make, while, by avoiding the expenses of importation, it is afforded at less than half the price of the foreign article.

The Malt from which it is made, is obtained by carefully malting the very best quality of selected Toronto Canada Barley. The Extract is prepared by an improved process, which prevents injury to its properties or flavor by excess of heat. **It represents the soluble constituents of Malt and Hops**, viz: Malt Sugar, Dextrine, Diastase, Resin and Bitter of Hops, Phosphates of Lime and Magnesia, and Alkaline Salts.

Attention is invited to the following analysis of this Extract, as given by S. H. Douglas, Professor of Chemistry, University of Michigan, Ann Arbor.

TROMMER EXTRACT OF MALT CO.—I enclose herewith my analysis of your Extract of Malt:

Malt Sugar, 46.1; Dextrine, Hop-bitter, Extractive Matter, 23.6; Albuminous Matter (Diastase), 2.469; Ash—Phosphates, 1.712; Alkalies, .377; Water, 25.7 Total, 99.95.

In comparing the above analysis with that of the Extract of Malt of the German Pharmacopœia, as given by Hager, that has been so generally received by the profession, I find it to substantially agree with that article.

Yours truly, SILAS H. DOUGLAS,
Prof. of Analytical and Applied Chemistry.

This invaluable preparation is highly recommended by the medical profession, as a most effective therapeutic agent, for the restoration of delicate and exhausted constitutions. It is very nutritious, being rich in both muscle and fat producing materials.

The very large proportion of Diastase renders it most effective in those forms of disease originating in imperfect digestion of the starchy elements of food.

A single dose of the Improved Trommer's Extract of Malt, contains a larger quantity of the active properties of Malt, than a pint of the best ale or porter; and not having undergone fermentation, is absolutely free from alcohol and carbonic acid.

The dose of adults is from a dessert to a tablespoonful three times daily. It is best taken after meals, pure, or mixed with a glass of milk, or in water, wine, or any kind of spirituous liquor. Each bottle contains 1 1-2 lbs of the Extract.

Our preparations of Malt are for sale by druggists generally throughout the United States and Canadas, at the following prices:

EXTRACT OF MALT, With Hops (Plain),	\$1.00
" " " " Pyrophosphate of Iron (Ferrated)	1.00
" " " " Cod Liver Oil.....	1.00
" " " " Cod Liver Oil and Iodide of Iron.....	1.00
" " " " Cod Liver Oil and Phosphorus.....	1.00
" " " " Hypophosphites.....	1.50
" " " " Iodides.....	1.50
" " " " Alteratives.....	1.50
" " " " Citrate of Iron and Quinia.....	1.50
" " " " Pepsin.....	1.50

Manufactured by

TROMMER EXTRACT OF MALT CO.,

FREMONT, OHIO.

FIG. 6.—Anterior view of the tumor described by Dr. Hodgen on page 179. [From a photograph taken during life.]

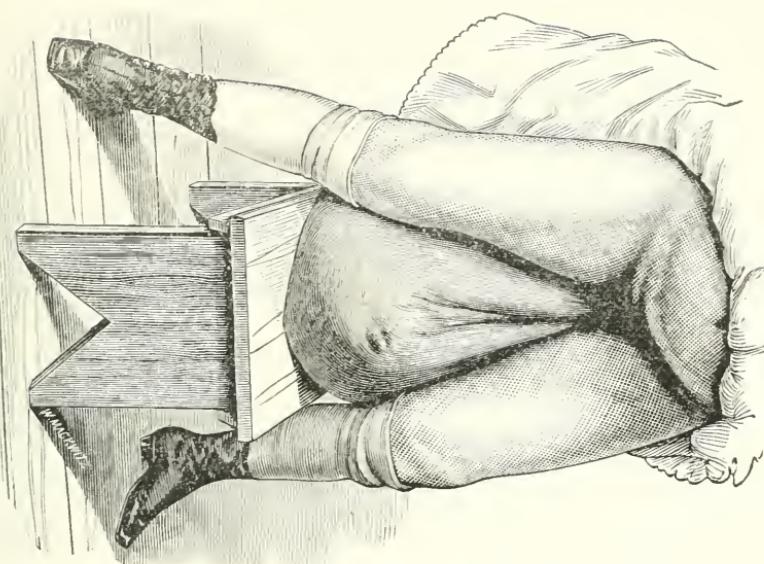
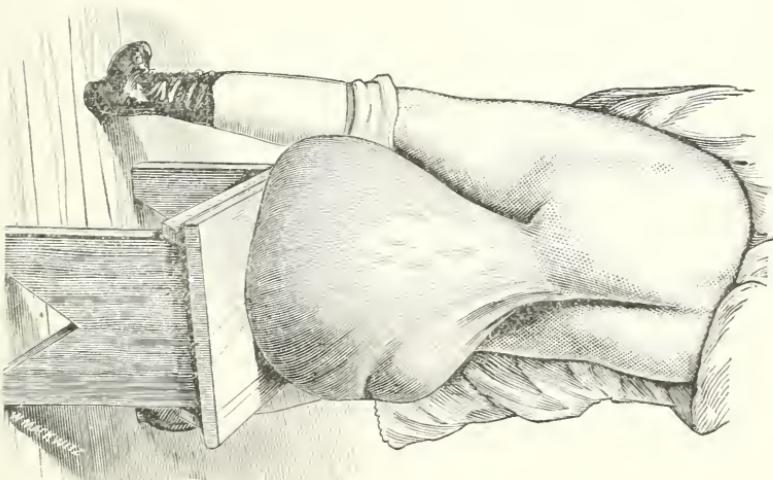


FIG. 7.—Posterior view of the same tumor. [From a photograph taken during life.]



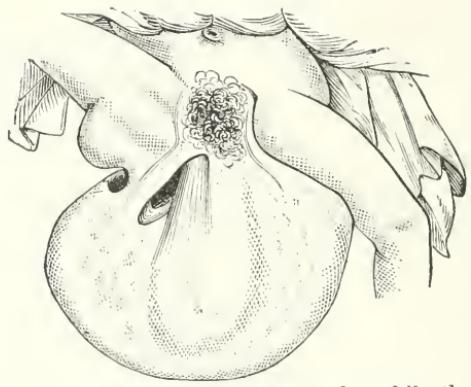


FIG. 8.—A diagram taken after death, while the subject was lying on her back. Weight of tumor 96 lbs.

Vaginal Enterocoele.

SEPTEMBER 14th, 1878.

DR. HODGEN:—By the kindness of Dr. Jennings, of East St. Louis, I am permitted to present this enormous tumor to the Society. The patient, Mrs. —, aged 40 years, was married and the mother of two children, aged respectively 16 to 14 years. The attention of the family physician, Dr. Illinsky, was first called to the tumor in Sept. 1873. In May, 1874, Dr. Jennings and myself saw the case, though not in consultation. At that time I found the tumor about the size of a goose egg, occupying the left labium. The tumor could be returned into the abdominal cavity and pushed entirely beyond the reach of the fingers in the vagina, but returned at once when the patient resumed an erect posture. There was at that time no question as to its character. It was a hernia, passing down beside the bladder and vagina and passing through the pelvic outlet. The patient was directed to wear a suspensory and remain as much as possible in a recumbent posture. About this time the patient complained of a painful fulness of the tumor about the menstrual period, and there was a sense of inability to pass the urine. Dr. Jennings, on introducing the catheter, found that it passed for a short distance in the usual direction and turned to the left, toward and into the tumor; but little urine was drawn off. The tumor continued to grow and the painful tension to increase with each menstrual period, until May, 1878, when Drs. Jennings, Fairbrother, Mudd and myself, made the following observations: Percussion elicited no resonant sound; a fluctuation was noticeable, a gum catheter passed nine inches into the tumor and could be distinctly felt through its anterior wall; but little urine was discharged. The perpendicular length of the tumor was 20 inches, the greatest circumference 53 inches, circumference of the neck 21 inches, weight 94 pounds. The uterus was found turned to the left with its body lying almost horizontally in the pelvis. The entire left labium had disappeared in the tumor and the left vaginal outlet formed a part of its covering, while the anus was an oblique opening on the side of its upper part.

JUNE 4TH, 1878.—The photographs were taken during the interval of menstruation. On June 6th the following measurements were taken by Dr. Jennings: Vertical length 17 inches, greatest circumference 43 inches, circumference of neck 21 inches, weight 64 pounds. About the 25th of July had a severe attack of intermittent fever, from which she recovered promptly under the care of Dr. Jennings.

On Sept. 5th a chill of unusual severity, reaction not being established in less than four hours, notwithstanding the vigorous use of the means deemed most effectual in such cases; dur-

ing reaction the temperature reached 104° F., and continued until the following morning, when the temperature was nearly normal, and there was a corresponding abatement of other febrile symptoms. Quinine was given in full doses, but during the night the temperature began to rise and reached 105° F.; delirium set in; several livid spots appeared on the surface of the tumor and spread rapidly. The following day, in consultation with Dr. Mudd and myself, Dr. Jennings continued the quinine in full doses. She sank and died at 1 A. M., Sept. 8th. Post mortem made Sept. 8th, 10 hours after death, in the presence of Drs. Jennings, Fairbrother, Sesson, Mudd, Barrett and Mr. Black, Mr. B—making the sketch from which the drawing presented was taken. An incision was made from the ensiform cartilage to the pubis. The stomach was found entirely to the right of the median line, the left end being to the right and opposite the umbilicus; the colon ascending obliquely from the right iliac fossa, across the abdominal cavity to the left, and thence downward into the pelvis. On drawing the colon out of the pelvis the omentum left the hernial sack, and was drawn into the abdomen through the pelvis; passing the hand through the pelvis into the sack, a part of the omentum still remaining there, and it is probable that the colon formed a part of the hernial tumor. The uterus and both ovaries were found in the pelvis, the uterus lying across the pelvis, with the fundus to the left. The urethra turned immediately downward, opening into the bladder, which formed a part of the tumor, but not a part of the contents of the hernial sack. The sack contained about a gallon of serum. The neck of the sack allowed the hand to pass easily into the sack, which, as it lay flattened in the tumor, measured 12 inches in diameter. The skin was enormously hypertrophied, while its deeper layer was continuous with the hypertrophied connective tissue, and both were succulent with serum, forming nine-tenths of the tumor, which weighed 69 pounds after removal. Half a dozen blood vessels as large as the little finger, passed from the iliac vessels into the tumor.

DR. TUHOLSKY:—From the history of the case I have no doubt that Dr. Hodgen's diagnosis in the beginning was correct. There are a few points in it that lead me to think this is a hernia of the labial masses, leading down through the inguinal canal. The first is the difficulty that occurred at each monthly period. The uterus passing down into the canal and filling with blood would naturally compel the tumor to fill with it. Then again the omentum was down in that large sac. After a time there was a decrease of weight and I daresay the omentum decreased considerable. There may have been a good deal of omental fat which decreased materially and diminished the measurements of the tumor in every direction. As far as the hypertrophy of the tissues is concerned, it is probably not

greater than would be incident to a long œdema in an old rupture passing on into the labium.

DR. HODGEN:—I must correct the impression made on the Doctor's mind. There can be no question of the hernia, because I made an opening and passed my hand through the pelvic cavity—it undoubtedly came through the inferior outlet of the pelvis, not along the course of the inguinal canal. When first seen by me I was satisfied that it was a hernia, but more recently I was led to doubt my diagnosis from the enormous size it had attained and because no great amount of material could be returned from it. The variations in size of the tumor and the pain connected with it at each monthly period, Dr. Jennings and I attribute to congestion of the uterus and appendages at this period, and the unusual flow of blood into the vessels of the tumor occurring in connection with it. The enlargement being due to that congestion, and the œdema consequent upon it and the diminution to a subsidence of the congestion and absorption of a portion of the serum.

DR. MAUGHS:—This tumor evidently came down by the side of the vagina, carrying a portion of the vagina with it. It must have come down on the inner side of the levator ani muscle, nearer the bladder, then carrying the bladder more down than the uterus. I think at the first glance that it was probably a retroverted uterus in the beginning; that the fundus had penetrated Douglas' *cul-de-sac* and was pushed down by the vagina. I do not say that this was the case, but I think it may have been. Beginning as a retroverted uterus the intestines kept pushing it down until it presented itself in the labium major, the uterus being driven down further and further and the bladder dragging down until it was turned upside-down, so that a catheter when introduced through the urethra, first entered the pelvis and then turned down out of it. The nutrition of this part increased by the abnormal irritation, favored the development of an enormous sarcomatous mass. It was a tumor composed of omentum, of a uterus, of a bladder, pressed down by the intestines, producing an enormous hernial mass. If I could get a uterus in that position I could see the rest very clearly, and see no difficulty in getting an enormous hernia made of displaced viscera, a tremendous hypertrophy from the irritation that was kept up and additional swelling from œdema, the size of the whole tumor lessening or increasing according to the absorption of the serum. The positive demonstration of Dr. Hodgen has made it clear that it was not an inguinal hernia as I first thought it might be.

DR. HODGEN:—I do not know whether I followed Dr. Maugs

correctly, but he seemed to think the uterus formed a part of this tumor.

DR. MAUGHS:—I thought so.

DR. HODGEN:—I now state distinctly that the uterus was within the pelvis; that the bladder was below the outlet of the pelvis; that the uterus was turned over on the side, but was distinctly above the inferior outlet of the pelvis and did *not* form a part of the tumor.

DR. MAUGHS:—I supposed at first that the uterus was in the tumor, but as it is not, then it is simple hernia. It is a vaginal enterocele, of which a case is reported in THE ST. LOUIS MEDICAL AND SURGICAL JOURNAL a few years since, which presented a sausage-shaped body through the vulva for four or five inches and covered only by mucous membrane. The woman was completely relieved by an operation. In this case it presented in the labium instead, carrying with it the bladder instead of the uterus.

DR. FORD:—I would like to ask of Dr Hodgen if he is cognizant of the history of this case—at what point the tumor first appeared?

DR. HODGEN:—To my recollection, the tumor was by the side of the vagina and could be pressed back into the cavity of the pelvis; it was situated anteriorly to a median transverse plane, and nearer the side of the bladder than of the uterus, perhaps a little in front of the latter organ. It is now four years since I observed these points, but I think I am correct though I made no record at the time. I remember distinctly the protrusion was on the left side, appearing as if it passed into the labium rather than into the neighborhood of the rectum; I think it must have passed rather in front of the vagina.

DR. FORD:—It would then appear to have been originally a vaginal and not an inguinal enterocele. Under this assumption it is a well recognized though rare form of hernia. In the course of its descent, protruding still further, it passed along the wall of the vagina, finally entering the labium. There it seems the labial tissues became abnormally developed, and it is probable that this increased growth, stretching the pelvic structure by its weight, caused an enlargement of the original sac. Into this pouch the organ lying nearest would be drawn by a kind of aspiration, supplemented by the pressure of the abdominal muscles. The bladder was then found in the sac, having, perhaps, prevented the uterus from entering it. We must recollect the great disposition of the labia and adjacent parts in the female, towards the formation of what are called fibro-cellular tumors, whose structure evinces loose, fatty lobulations, at times, the

skin not being necessarily thickened. This enormous tumor appears to me to be of that character, of which elephantasis is really a variety only. The tumor before us, seems to be closely allied to what is called *lipoma myxomatousum*, a class of pear-shaped, pendant, pedunculated tumors that sometimes grow to a very large size.

Multiple Abscess of the Liver.

DR. ROBINSON presented a specimen of multiple abscess of the liver and said : This is an interesting case because I believe it to be of idiopathic origin. The patient was taken sick about three weeks since and a few days later I saw him for the first time. He had been previously in good health, though recently there was some gastric disturbance, presumably due to excessive use of alcohol. His sickness began with a chill followed by fever when I saw him. These symptoms were present : He was restless, and tremulous in his movements; sleepless; the skin hot and dry; the evening temperature $104\frac{1}{2}$; the tongue dry and covered with a thick white fur, and the bowels greatly constipated ; I found his abdomen distended and tympanitic, but there was no tenderness except in the right hypochondrium. There was dullness almost at high as the right nipple, extending some distance below the ribs and over the hypogastric region. My diagnosis was acute hepatitis ; I ordered a few grains of chloral and gave him small doses of merenry, followed by sulphate of magnesia, hoping to unload the liver by producing a watery discharge from the intestinal canal. At the end of a week the tongue began to clean off and there was less general pain about the liver, although the abdomen remained distended. The pain soon became circumscribed and there was a good deal of hypogastric tenderness. In a few days after this temporary improvement, several large discharges of blood took place. The patient from this time grew weaker ; the pulse more feeble ; the high temperature and circumscribed pain remaining, and six days ago he died. At the autopsy, thirty hours after death, we found a large abscess in the upper posterior part of the right lobe of the liver, containing nearly a gallon of pus. Other small abscesses were found in different portions of the liver. The organ was adherent to the diaphragm and the lower margin of the right lobe to the colon ; the gall-bladder was also adherent to the colon, but these adhesions were easily broken up, showing them to be recent. The small intestines were pale, but the large intestine was dark, almost purple in color, filled with grumous bloody material, resembling in appearance currant jelly. The case is interesting because the disease ran so rapid a course, lasting only

three weeks from its incipiency. In such cases, which are rare, the formation of pus is very extensive, and the abscess is generally found in the posterior portion of the right lobe as in this case.

DR. MOORE:—There is no doubt but that alcohol exerts a very decided influence as a cause of hepatic disease, not only as a direct irritant of the liver but also on account of the sympathetic connection that exists between the stomach and the liver. Alcohol acts as a direct irritant to the liver by being absorbed and finding its way through the blood channels into the hepatic tissue, as alcohol, where it is well known to produce hepatitis. Again there is a great sympathy between the stomach and liver and this for a three-fold reason: 1st, from associated function. 2nd, from continuity of tissue. 3rd, from proximity of parts. We have an illustration of sympathy from associated function in the sympathy existing between the mammae and the uterus in pregnancy, not more intimate however, than that existing between the stomach and liver. The mucous membrane of the stomach is continuous with that of the duodenum and common duct, and so into the liver tissue. The stomach and liver are in close proximity and that sympathy exists between organs in juxtaposition we have but to remember the influence that may be imparted through the rectum to the uterus. I suppose that in the case referred to, alcohol gave rise to hepatitis, first as a direct irritant, and secondly through the intimate sympathetic connection existing between the stomach and liver.

DR. FORD:—The correctness of Dr. Moore's views are obvious. The facility with which the stomach absorbs alcohol is exceedingly great, and this finding its way into the liver readily produces proliferative changes in that organ, which ends in the formation of connective tissue. Other irritants taken into the stomach for a long period may produce similar results. I believe that much of the injurious effects of warm climates is due to the large amount of spices used, especially by those not fully acclimated. I have within a few days seen a case similar to that reported by Dr. Robinson. The patient from the South, a resident of St. Louis for two months, had used alcoholic drinks to excess, and lately had been drinking large quantities of beer, which is especially liable to induce disturbance of the hepatic functions. I saw him on the evening of the tenth day of his illness; he was intensely jaundiced, the skin was not dusky but dry; the lips covered with sordes, and the tongue black; the temperature was abnormal and the patient was restless and profoundly adynamic; the pit of the stomach and right hypochondrium were sensitive; he passed urine constantly but it contained no albumen; his bowels moved frequently, and the dejections contained no blood but were very offensive; he had had vomiting, but it now ceased; he had had delerium tremens at first,

and there was evidently nervous excitement associated with the prostration. I believe that this was a case in which a chronic hepatitis had been awakened into activity by excess. I was unable to obtain a post mortem examination. The pressure of the bile in the blood, all writers admit, produces the tendency to hemorrhage which we find associated with jaundice. The jaundice in this case was possibly due to inordinate hepatic action in portions of the liver not yet affected by inflammation, progressive therefore, and due to hyper-action of the liver in conjunction with partial occlusion of the bile ducts. The effects of the bile upon the blood in producing a tendency to hemorrhage is very well pointed out in a case of cholecystotomy by Marion Sims, of Paris, lately detailed in the *St. Louis Clinical Record*, in which there was occlusion of the bile duct. After the operation the patient did well for a few days but eventually sank. Dark grumous matter was found in the intestines and the stools and vomited matter were identical in appearance with the black vomit of yellow fever. It is not known whether the coloring matter of the bile acts deleteriously upon the blood; our knowledge with regard to the injurious influence of the biliary acids must be regarded as well established.

DR. STEVENS:—I agree to his proposition that alcohol may cause abscess of the liver, but surely the proximity of parts cannot have much to do in determining the disease. If we grant that the gastric wall absorbs alcohol readily in a pure form, still it cannot pass into the liver, for between the two organs are two layers of peritoneum. Again, as regards associated function, there are other organs just as intimately connected with the stomach as the liver, for instance, the pancreas, the intestines and mesenteric glands which are not usually affected by alcohol. We know that often those who suffer from abscess of the liver are those who have long been addicted to the use of alcohol, but I do not think that the reason why this should be has been given to-night.

DR. ROBINSON:—The patient whose case I presented was, though addicted to the use of alcoholic drinks, scarcely in the strict sense of the word a drunkard. While I believe that alcohol is often the cause of inflammations such as this is, I do not think it passes directly through the gastric walls, but it passes through the portal veins and irritates the connective tissue immediately surrounding the interlobular veins, and so produces a chronic inflammation which we call cirrhosis and is usually accompanied by dropsy. In this instance the inflammation was acute and very likely of the same pathological nature as acute cirrhosis. I would lay stress upon some of the symptoms occurring in this case, which I have seen in two other similar cases. One is the character of the tongue. In each of these cases the tongue was dry and covered with a very thick white coating, another is the

discharge of bloody stools, and a third symptom is that there was very little jaundice. This last characteristic is in accordance with Niemeyer's statement that jaundice is not an evidence of organic disease of the liver, but rather of functional disturbance of that organ, except in cases of acute yellow atrophy.

DR. BERNAYS:—The case related by Dr. Ford was that of an intimate friend of mine, who while in Europe drank large quantities of beer, but during the last half year since his return to this country he drank whisky. His symptoms were widely different from those in the case reported by Dr. Robinson. He was greatly jaundiced and his dejections were black. This morning I saw an old toper, with a large liver, but little jaundiced, and thickly coated tongue, corresponding to the class of symptoms spoken of by Dr. Robinson. He was tapped in several places, but only an ounce of pus came away at each puncture. There were evidently small multiple abscesses. I expect a fatal termination of the case before long. When there is interstitial inflammation, contraction takes place and dropsy results from compression of the blood vessels and ascites. I never saw a post mortem examination in a case of cirrhosis of the liver in which ascites was not present. It seems that this climate favors the development of this condition. In Europe they always ask a patient who has hepatic abscess if he has lived in India or the Southern States.

DR. MOORE.—I wish to indicate my position regarding the manner in which alcohol produces hepatitis. There can be no question that alcohol gets into the hepatic circulation, and further, we know that one of the functions of the minute veins and capillaries is the absorption of fluids. One of the important offices of the vessels of the pleura and peritoneum is the absorption of the serum which is poured out for the purpose of lubrication and we see this same effect resulting when under treatment; the absorption of ascitic effusion is accomplished. I believe therefore that alcohol may pass directly into the circulation through the gastric veins.

DR. STEVENS:—Dr. Moore is undoubtedly correct in his statement as to the absorbing power of the stomach and that alcohol may reach the liver unchanged, but the point is, it is not as a direct irritant that it causes hepatic abscess. We do not see these abscesses in those who are recent drinkers. If I drink freely today I do not expect hepatic abscess to-morrow, but it is where certain degenerative changes have taken place that suppuration occurs in this organ.

DR. FORD:—It is by way of the veins that fluids are absorbed from the stomach and taken into the liver. Alcohol, it is well-known, and I say positively, is more directly and quickly absorbed into the stomach than any other ingestum whatever—

except, perhaps, ethers, which are allied substances, as I have already remarked. I think it is exceedingly probable that the absorption of a direct irritant of that kind, ammoniacal preparations, as has been proved years ago by Harley—condiments, alcohol and tobacco smoke swallowed, will induce chronic inflammation of the liver.

But there is still another point which Dr. Stevens has suggested. It is well known that starchy and saccharine matters irritate the liver almost as much as alcohol. I have seen a case of hepatic abscess in which the infection of the liver was, as far as I could make out from the history of the case, in no way due to ingestion of alcohol, but, on the contrary, the patient was admitted by his friends to have been in the habit of taking enormous quantities of sweet substances. Saccharine matter is taken into the circulation directly by the venous twigs of the walls of the stomach and intestines. Now, it is known that the production of glycogen in the liver is enormously stimulated by ingestion of starchy or saccharine matters. Fatty matters act in an entirely different way, but it is not so with starchy matters. They are acted upon by the various juices of the intestinal canal; they are changed by the different juices into dextrose and glucose, and pass directly into the liver.

It is very probable that alcohol may have a similar effect in quickening the nutritive process of the liver. One of the commonest rules of pathology is that where there is constant functional excitement of an organ, proliferative changes will sooner or later manifest themselves. If the irritation is continued, congestion occurs, and finally inflammation declares itself. When inflammation is thus kindled, its course will be determined by the constitutional state of the subject. If the diathesis should be rheumatoid or sub-rheumatoid, a condition of the system averse to suppuration, we have connective tissue formation, with ultimate cirrhotic contraction, fibroid degenerations, and the like. If the inflammation occurs in an economy whose diathesis is suppurative, abscesses will occur.

Very few cases of primary acute hepatitis have fallen under my observation. Such a thing may occur by impaction of the gall-stone, or other obstruction of the gall-ducks. Acute hepatitis, in my experience has, with such exceptions, perhaps, been invariably due to exacerbation of previous chronic liver disease.

DR. BERNAYS:—I would like to know whether the question has ever been investigated as to the origin of jaundice in yellow fever. Is it hepatogenous, or is it haematogenous?

DR. FORD:—That has been a matter much controverted. At one time it was universally regarded as haematogenous. I supposed so myself, but within the last eight or ten years I have changed my ideas, and regard it as due to inordinate acute hepatic action.

DR. HUGHES:—I would recall a case I reported last spring in which hepatic abscess was found in a man who had used large quantities of lager beer. The immediate cause of the abscess was a cold which implicated the lungs also. I presume in this, as in the most of the cases of acute hepatitis in persons accustomed to drink, that there is some exciting cause, such as blows, injuries of other kinds, or exposure to cold such as those are liable to who drink to excess. From my reading on the subject I have not concluded that alcohol is the direct cause of abscess of the liver or that the use of it necessarily terminated in abscess, but that it produced a condition which predisposed the liver to become the seat of acute inflammation with abscess consequent. I observed in this case the symptoms spoken of by Dr. Robinson.

DR. PREWITT:—I think there is too much stress laid upon the effect of alcohol in producing abscess of the liver; such a result, if it occur, is exceedingly rare. All authorities teach that alcohol does not produce acute hepatitis, but rather a plastic inflammation and Dr. Stevens is doubtless right in his idea that where we have acute inflammation of the liver in one who has used alcohol to excess, that there is something else behind it—some already existing cause which may be aggravated by the use of alcohol. If this were the usual cause of hepatic abscess, then this condition would occur more frequently, and I venture the assertion that it occurs as frequently in those who do not drink as in those who do.

DR. MOORE:—I do not think that alcohol causes acute hepatitis and among some ten cases of abscess of the liver not one was addicted to drink. In my experience this condition more frequently results from dysentery. It is common for a man to go to India and return a Nabob with liver disease owing to the climate. Drinking is as common in England as in South Carolina, but in the former country abscess of the liver is a rare condition. I have seen many old topers with enlarged liver, but never one who died from abscess of the liver. It produces rather a chronic hepatitis not likely to result in abscess unless under peculiar circumstances.

DR. A. GREEN:—I have had two cases in the last six months, neither of them drinkers, one of them a lady who did not drink even beer.

DR. JOHNSTON:—I am inclined to the belief that alcohol does indirectly lead to hepatitis. Alcohol is a hydro-carbon and when taken into the system there is an excess of hydro-carbon. The office of oxygen in the system is to “burn off” the effete matter of the human system. If the oxygen is consumed in combustion with the alcohol there is a super-abundance of fatty matter remaining in the system, and the liver suffers from an excessive amount of hydro-carbon; hence we have fatty degeneration. A

change of temperature occurs, the perspiration ceases and the liver is left congested, and if any sudden irritation now occurs, acute hepatitis may result. Thus the alcohol may be indirectly the cause of the abscess, when if the patient had not used it, he might have escaped the disease. As far as the climate of India is concerned as a cause of hepatitis, we know that those who go out from Germany and England persist in their usual diet—roast beef, etc., and the system will not stand so much hydro-carbon in that climate.

Osseous Tendon and Intra-Capsular Fracture of the Femur.

DR. MUDD:—I have here Mr. President, two specimens taken from a man aged seventy-nine. The subject was found in the dissecting room, and the certificate of death indicated only senility. This piece of bone, six inches long, varying in width from one-half an inch to an inch, was taken from the upper portion of tendon of the semi-membranosus, near its attachment to the ischium. This is osseous tissue and not a calcareous degeneration. I found also a large sessamoid bone in the outer head of the gastrocnemius. These were found in the right leg. In the left, this intra-capsular fracture of the femur was found.

Here the acetabulum is roughened, especially in the upper part of the smooth rim that articulates with the head of the femur and in the depression to which the ligamentum teres is attached. The upper posterior margin of acetabulum is thickened and has a small osteophyte springing from it.

The femur presents an intracapsular fracture of long standing ununited and indicating conditions which make it a most comforting specimen to the surgeon. The detached head of the bone maintained its connection with the ligamentum teres and retained its vitality by nourishment through the vessels accompanying the ligament and by imbibition, but not sufficient to make any changes in the line of fracture nor any marked change in the character of its osseous tissue. The line of fracture is smoothed a little at points of fracture, but represents very nearly the fracture as it originally occurred.

Very different is the appearance of the shaft, for the neck has disappeared by absorption; about the site of its junction with the shaft we have a number of osteophytes. One springing from the lesser trochanter, projecting downwards and forwards, is at least two inches long; running obliquely forward and upwards from the lesser trochanter, a semi-circular rim-shaped band, projects from the inner surface of the shaft, with an attached border fully two inches long and standing out from the shaft at least an inch; into this fitted the head of the bone and it gave to the limb its support and made it no doubt a useful leg. The leg must have been at least three inches short, but with the head in the acetabulum, and at the same time holding firmly its relation to the femur, resting as it does in the osteophytic

ring formed for it on the femur, it indicates strength in the limb and a limited amount of freedom in its motions. The digital fossa is filled with the bony deposit and a number of small osteophytes are attached to the great trochanter. The vitality of the head was sufficient to prevent necrosis but not enough to permit any reparative action. There was sufficient osteoplastic power in the femur to have secured firm union if the head had possessed more vitality.

This specimen is a source of comfort to us because it indicates very clearly the conditions which prevent union and make the best directed efforts in the treatment of this fracture abortive. The most perfect apposition of fractured ends, maintained an indefinite time, would have failed to accomplish union. Again the situation and shape of the semi-circular cup-shaped ring of the femur in which rested the head, demonstrated the importance and utility of the treatment frequently adopted in this fracture. The shaft of the femur was drawn upward by the immediate contraction of the muscles; the inferior border of the head rested against the shaft at the inferior extremity of the anterior inter-trochanteric line, and osseous deposit appeared at this line of irritation but gradually; as the muscles slowly shortened the trochanters were drawn higher and the rim of the bone advanced in front of the head as it dropped downward along the shaft so that the cup in which it ultimately resulted was at least an inch below the point at which it was attached to the shaft. This shortening as also a part of the primary retraction, might have been prevented by continued extension. Hence it is that in these cases where we do not expect to obtain union we get a better result by keeping the patients quiet with continued extension for two, three or four months till these osteophytic deposits are made, and these osseous changes have occurred.

The following paper on "Dropsy of the Amnion" was read by Dr. Newman:

MR. PRESIDENT:

In the *Obstetrical Journal of Great Britain and Ireland* for July, 1878, is published by Dr. Griffith a very interesting case of hydramnios. As I desire to make some remarks on dropsy of the amnion, I will as an introduction to the subject, quote a single paragraph from Dr. Rauth, who also saw this case. In speaking of it he says: "This case is a puzzle; breasts, areola very large, but pimples thereon imperfectly developed; abdomen contains a tumor that reaches to ensiform cartilage, harder than occurs in pregnancy; obscure souffle, not tubular; no foetal sound or double cardiac sounds; vagina and uterus not blue; os large, capacious and velvety, feeling like advanced pregnancy; is patent, admitting the finger; ballottement obscure, could not be accurately made out, owing to the pain produced on examination; great pain on pressure of uterus. I cannot diagnose certainly, but would

say pregnancy, probably with ovarian disease. The case remained under treatment from October 24 to November 13. On the 12th of November in connection with some movement of the body, the membranes ruptured and a large quantity of water was discharged, and on the 13th of November the woman was delivered of twin females; one was putrid the other had died more recently. After delivery the woman rapidly recovered. The pregnancy had not reached the sixth month. At a very early period of pregnancy she had pains in the abdomen for twenty-four hours, after which she rapidly increased in size until her condition became uncomfortable and painful." While many writers on obstetrics refer to over distention of the uterus as a cause which may complicate and retard labor, very few have anything to say about dropsy of the amnion coming on at an early period of pregnancy and the suffering and danger which it entails. The paucity of literature on this subject, is such as to furnish but little information, either as to the etiology, pathology or treatment of, this disease. Caseaux very briefly refers to it. Hewitt records a few cases and speaks of it as a rare disease. David Davis mentions three cases. Dr. Robt. Lee in a very large obstetric practice met with but seven cases. In his great work on obstetrics, Dr. Hodge has a very elaborate article on dystocia, in which he speaks of hydrops gravidarum, and dropsy of the child as a condition obstructing labor, but if I mistake not he is reticent on the subject of dropsy of the amnion, as connected with early pregnancy, and yet the suffering which it might inflict upon the mother and the danger to the child is such as to mark it as a disease of great importance, and it has certainly received less attention than it demands, when its frequency and gravity are considered.

The cause of the disease and the anatomical lessons connected with it are involved in great uncertainty, but as in its treatment we have to do with an effect rather than its causation, a knowledge of these is not so important as in many other diseases; nevertheless in a scientific point of view it is well for us also to inquire into these. I will therefore refer to some of the speculations as to the etiology and pathology of the disease, with a hope of arriving at some satisfactory conclusions.

As soon as the impregnated ovum reaches the uterine cavity it is found to be invested by membranes, chorion and amnion, which forms a sack containing a fluid in which floats the germ or future fetus. This fluid is then ever present and increases in quantity *pari passu* with the growth of the child, and is doubtless produced by the amnion, as suggested by Dr. Hodge, and is for the purpose of conserving the well-being of the mother and child, and must therefore be regarded as physiological in origin and function, and therefore when excessive in quantity, may very properly be regarded as an exaggeration of function, involving no pathological changes. To my mind this seemed a very

plausible view of the subject. But in some cases the disease has been known to develop quickly and rapidly, after some injury or violence, and as in most cases it is attended with great tenderness of the abdomen. Some have regarded it as the result of inflammation. Dr. Marcin adopts the view without indicating the organs or tissues involved. Dr. Robt. Lee found symptoms of inflammation in several of his cases. When it is remembered that the natural disposition of the capillary system, is to seek relief by effusion, where inflammation or congestion exists, the inflammatory character of the disease seems not improbable. But this view would point to the amnion alone as the tissue involved. I will not here stop to inquire whether or not a tissue in which the blood vessels are so minute as not to be discerned by the naked eye, is capable of taking on an inflammation, but whether supplied with blood vessels or not, the amnion is a living tissue, and derives its nourishment from the blood by imbibition or otherwise, and must, therefore, be affected by properties of the blood.

Some modern pathologists have connected this form of dropsy with an impoverished and hydramniotic state of the mother's blood. Pregnancy was formerly regarded as a condition involving "an increased activity of the organic functions of the system," especially that of imbibition, so that in the early stages, it was contended that there was not only an increase of adipose tissue, but that the woman became physically stronger and more active and more sprightly in her mental conception. Indeed, increased nutrition was regarded as a wise provision of nature for the growth and development of the fetus and to prepare the mother for the great expenditure of labor demanded during child birth, and to qualify her for the new function,—lactation, which immediately follows. This view was generally adopted and is ably maintained by Hodge against the chlorotic and impoverished state of the blood now advocated by Cazeaux and many modern pathologists. That the blood in pregnancy undergoes important changes, with a great increase of its watery constituents, is well established. Nevertheless from the very nature of things it must be rich in the nutritive properties. This vitiated condition of the blood contended for by Cazeaux, is called toxicæmia, and predisposes to albuminuria, and uræmic intoxication, for the reason that when albumen is found in the urine, urea is imperfectly excreted and remains in the blood. Albumen in the urine during pregnancy is so constant that Cazeaux regards it as a physiological condition, but may become so exaggerated as to cause nephritis.

It, then, a vitiated state of the blood, predisposing to disease, is so constantly present in pregnancy, ought not pregnancy itself to be regarded as a pathological state?

Some years ago I ventured this suggestion before this Society, and if further investigation in this direction should lead to

this conclusion, it will be a verification of the Scriptures, which declares that the pain and sorrow connected with child-bearing is the infliction of a penalty for sin. "I will greatly multiply thy sorrow and thy conception. In sorrow shalt thou bring forth children." But admitting the watery and impoverished state of the blood, contended for by the new school, I cannot see why dropsy of the amnion should result from this cause, and the mother herself not be dropsical.

Lastly, the cause of this dropsy has been sought for in a diseased condition of the child. Under this head Dr. Hewitt says, in speaking of Dr. Griffith's case, "It may, in some way, have been connected with the death of the child, but how he cannot explain but by the law of endosmosis and exosmosis." That children in utero may become diseased, is doubtless true, and as, according to Hodge and others, urine may be excreted and discharged into the amniotic sack, it is within the scope of possibility that a child might have diabetes, in which case a large amount of urine might be passed. But in the cases which came under my observation, the water discharged contained none of the properties which characterize urine, and the children were certainly not dropsical. The presence of urine in the amniotic fluid must, I think, be very rare, and that it is connected with this form of dropsy is contradicted by the well-known fact that the dropsy usually comes on very early in foetal life, and when the children are born alive they have not been found diseased. This view, then, is rendered so improbable that it must be rejected, and besides, for the present, we must accept the theory that nutrition, excretion, and the vivifying qualities of the blood—respiration—are affected by the placenta, in some way, through the mother's blood, but just how we may not know. From what has been said of the cause of this disease, it will appear that but little can be said of its pathology. If it arises from an exaggeration of function, no change would be discoverable in the amnion, as already intimated. If it is connected with inflammation of the membrane, thickening, perhaps, with some congestion, would be found. But, as this membrane is subject to great diversity, sometimes being exceedingly attenuated and friable, and at other times so thick and tough as to be punctured with great difficulty, our conclusions derived from thickening are very unsatisfactory, yet all the cases which I have seen point in this direction, the membranes being very tough. But the most interesting aspect of this disease in a practical point of view, is its treatment.

As has already been seen, this complication of pregnancy comes on at an early period, usually before the child is capable of living if separated from the mother, and, as it is fraught with great danger to both mother and child, its treatment involves questions worthy of our profoundest consideration, both in a moral and professional point of view. When called to a case of this kind,

the first object of treatment should be to make the condition of the mother as comfortable as possible. This object will be accomplished, first, by hydragogue cathartics and diuretics (the bowels are usually torpid from pressure), with a view of relieving fecal accumulations, and thereby affording additional room, and also with the hope of promoting absorption, or failing in this, we may at least so withdraw serum from the blood as to lessen, in some degree, further accumulation. Secondly, we should resort to anodynes in order to relieve pain and to procure sleep. For the purpose of relieving pain, no remedy is comparable with opium in its various forms, but where there is dyspnoea, chloral and bromide potas. will sometimes answer an admirable purpose. This combination is especially useful in cases where there is much irritability with reflex action.

The next object of treatment should be to secure the continuance of pregnancy as long as possible, where we have reason to believe the child is living. The treatment above indicated is here applicable, also. Where the pulse is rapid and weak, digitalis will be found useful, steadyng irregularity, and imparting tone and strength to a heart made irritable by reflex irritation, while, at the same time, it acts on the kidneys—thus relieving in some degree renal congestion resulting from pressure. If at any time we become satisfied of the death of the child, I can see no reason why the woman should be permitted to remain in a painful and perilous situation when relief is readily attainable. I should therefore, in this case, rupture the membranes and invite delivery. But as it is often impossible to determine in these cases, the question as to whether the child is living or not, even after quickening, and with the aid of auscultation, for the reason that motion may be feeble, and as in a large bag of water, the child occupies the most pendant part of the cavity, motion or heart-sounds will be discovered with much difficulty. The induction, then, of premature labor becomes a very serious question, even where the safety of the mother is threatened. Indeed, the induction of premature labor, at any period of gestation, was regarded until recently as a crime, even when resorted to to secure the safety of the mother. By such men as Baude-loque it was opposed as being “unnatural and immoral, violating human and divine law.” Dr. Kelly, of London, informs us that, in 1756, a consultation of the most distinguished accoucheurs of that city, was held to decide upon the morality and practibility of producing labor prior to the full term in a case of contracted pelvis. After much discussion the operation was sanctioned, and performed with success. But on the continent of Europe the opposition on moral and religious grounds was yet greater; and Cazeaux informs us that it was first performed in France in 1831.

Statistics show that where artificial labor has been produced at a period ranging from the sixth to the eighth month, a major-

ity of the children have lived, while the safety to mothers has been but little less than at the end of the full term. The conclusion, then, is that when from *any cause*, it is believed that a safe delivery at term, to mother and child, cannot be accomplished, it becomes our duty to resort to premature delivery with a view to saving both mother and child.

Dr. Hodge very properly says that here it is not a question as to whether the practitioner is to determine between the life or death of the child, but what are the best means to deliver both mother and child from existing danger. It is a choice of evils, and the obstetrician is in duty bound to choose the least for his patient. He says further: "At the present day, it seems wonderful that any question of morals should have been discussed in connection with this operation," when circumstances demand it.

But a yet graver question may be presented in connection with the disease we are now considering, and that is: Are we justified, under the most desperate circumstances, in bringing on labor before the child has attained to the viable period? Upon this question it may be said that the professional mind is divided. Speaking upon this subject in connection with extreme pelvic deformity, Dr. Hodge says: "The conclusion seems unavoidable that, in the present state of our knowledge and experience, that abortion is justifiable to secure the life of the parent." If this view be correct, it follows that it must also be proper where, from *any cause*, the case seems equally desperate. But I will not discuss this question in this connection, and will only say that I can conceive of conditions which might arise in connection with the disease we are now considering, under which I should consider it my duty to bring an abortion before the viable period. This seems justifiable, because the child is very often dead, and, as we cannot always decide this question, we may act upon the presumption of its death, when the mother's safety is in great jeopardy. But in this matter every one must act upon his own conviction of duty, not forgetting that it is written "Thou shalt not kill."

In conclusion, I will detail briefly a few cases of dropsy of the amnion which have come under my observation.

Some time in 1876 I was requested to see Mrs. T., wife of a physician of this city. I ascertained that she was over seven months advanced in pregnancy. She was exceedingly thin and emaciated and was evidently laboring under advanced phthisis, from an hereditary diathesis. Her abdomen was very much distended, and the movements of the child could be readily felt through its attenuated walls. Her suffering from dispnea was so great when she attempted to lie down that she was unable to do so, and even in the erect position she was constantly coughing and panting for breath. Her general appearance was that of great distress and suffering. She had not been able to sleep

but a few minutes at a time for many nights. In short her situation seemed so wretched and helpless as to enlist my deepest sympathies. I informed her husband and attending physician, that it was my opinion that unless relieved by the induction of premature labor she could not possibly survive one week, and that in her desperate condition this would involve great danger, but offered the only hope to mother and child. But the operation was at that time declined. As opium had failed to produce sleep, I ordered that at night she should take chloral grs. xx with bromide potass. grs. xxx. This had a most delightful effect, the patient sleeping comfortably during the greater part of the night, so that she was much refreshed, and all parties felt encouraged. But her suffering soon returned, and the chloral mixture no longer gave relief. Some days after this her husband again called on me, and desired that I should bring on labor as he thought his wife could not survive more than a few days if not relieved. I therefore with some difficulty ruptured the membranes, which was followed by a large flow of water, with immediate relief, the patient being able to lie down with comparative comfort. I then ordered an opiate and that night labor came on, and she was safely delivered by her attending physician of a living child. Both mother and child did well during the puerperal period, but some months after the mother died of consumption, and a few months later the child died of the same disease.

CASE II.—On the 7th of August of the present year, I was sent for to visit Mrs. W., a large, well-formed woman, aged about 40 and the mother of a numerous family of children. On my arrival I found her walking the floor, to give relief, as she said, to a painful and uncomfortable feeling in her legs, which were much swollen below the knees. There was also slight tumefaction of the thighs. The large size of the woman, together with the distention of the abdomen, gave the general appearance of dropsy, but there was neither anasarca, except in the legs or puffings of the face. She was 7½ months advanced in pregnancy, and informed me that her difficulty began at about the middle period, and near the sixth month she began to be troubled with shortness of breath, which from that time increased, so that before the seventh month it became so great that it was very difficult for her to lie down, and during the excessively hot weather of July she spent most of her nights in a sitting position in an open porch, ever and anon walking-about to give relief to her aching limbs, and when nature became utterly exhausted she would obtain a few snatches of sleep by reclining her head upon the bannisters. The movements of the child had not been felt for over a week. About this time she consulted Madame Carpenter, who regarded the suffering in her legs as demanding the greatest attention. Ordered them to be poulticed with some powdered substance, which gave her such intolerable pain that she was compelled to abandon its use. She then called in her family

physician, who at once comprehended the situation, and very properly attempted to afford relief by active purgation with salts and cream of tartar. For a time this gave some degree of relief but the doctor became satisfied that her condition was becoming perilous, and informed her that she could only end her suffering by having delivery effected, and being himself unwilling to assume the responsibility, surrendered the case, and directed that I should be called. The woman and her friends were anxious to have labor brought on, believing that the child was already dead, as no movement had been felt for ten days. I examined very carefully for foetal heart sounds, but discovered none. A digital examination revealed turgency of the labia, and so much pain as to cause an involuntary withdrawal of the person, but by perseverance I succeeded in introducing my index finger but could not reach the mouth of the womb until two fingers were forced high up into the cavity of the sacrum. The os was found considerable dilated, so that I found but little difficulty in introducing my finger and pulling the neck down. I then forced in two fingers with which I continued to dilate until my fingers were exhausted. The head of the child was found pressing down with great force upon the brim of the pelvis, so that the membranes could not be distinguished from the scalp of the child, and as I had with me no instruments, it was impossible to rupture them, and hoping that the amount of dilatation which had been effected might induce labor, I ordered free purgation during the day, and at night directed twenty-five grains of chloral and thirty five grains of bromide potas. to be taken.

When I called next day I found my patient much more comfortable, having had a refreshing night's sleep, but there was no indications of labor; the bowels had been freely acted upon, but there had been but little urine secreted. Indeed, I learned that for sometime not more than eight ounces had been passed daily. An examination revealed that the neck of the womb had again taken its place high up in the cavity of the sacrum, and was not more dilated than when I had left. It was again brought down, and dilated as before, and a-half dram dose of fluid extract of ergot ordered every hour. At my next visit her condition was very uncomfortable; she had great pain in her back as though labor was coming on; there was tonic contraction of the uterus so as to give the whole abdomen the appearance of a firm elastic tumor, but there was nothing like regular labor pains; there was present such a state of hyperesthesia that the woman was unwilling to be examined without chloroform. I therefore determined to administer chloroform and rupture the membranes, which I at once proceeded to do. She readily went under the influence of chloroform, but the child's head was held so firmly upon the bones of the pelvis, that the membranes—which were exceedingly tough—were perforated with difficulty, great care being necessary lest the head should be injured. No discharge

of water followed the rupture of the membranes, until the head was forcibly pushed up with the finger. While the head was thus held the water flowed freely, but when about a quart had been passed, the woman having recovered from the chloroform, made a sudden lurch and dislodged my finger, when the flow stopped as suddenly as if a cork had been applied. I then had her placed in the genupectoral position, which gave rise to little further discharge, but the entire amount did not exceed a quart, but the removal of this much I thought would so relieve the disturbance as to restore contractility and enable the womb to expel its contents. I therefore again ordered ergot, and directed if labor came on in the night to send for me. I was called about midnight. Some very slight pain had been felt, but the general condition was unchanged. The tonic contraction of the womb was such that the child's head was held against the brim of the pelvis as if by a vice. The woman complained of cramps in her legs and was otherwise exceedingly uncomfortable, and being satisfied that labor could not be accomplished until distention was further removed, I determined to place her fully under the influence of chloroform; having done so, I introduced my entire hand into the vagina so as to afford the necessary power to force the head up. When this was accomplished, there was a gush of water beyond anything which I ever witnessed, and for some time it continued to flow as if from a hydrant fully turned on. The husband, who afterwards removed the bedding, informed me that he thought the quantity was not less than two gallons, and I am inclined to think the quantity was not over-estimated. In about three hours she was delivered of a child, partly decomposed, but large for seven and a-half months. The woman recovered without puerperal complication. There is in connection with this case a practical question of no ordinary interest. Was this woman, who for some time had evidently been suffering from renal congestion, and who passed urine very sparingly, saved from puerperal complication by excessive purgation, thus causing the bowels in some degree to assume the function of the kidneys?

Fibroid Degeneration of the Uterus.

OCTOBER, 12, 1878.

DR. LEMON presented a fibroid tumor of the uterus, taken from a negress, about 65 years old—a patient of Dr. Newman's.

DR. NEWMAN:—Three years ago I saw this patient when she was suffering from severe pain in the left side and great tenderness over the abdomen. She insisted that there was a snake in her stomach, and gave me permission to make a post mortem examination. In a few months she began to get better, and I am satisfied that at that time it was a case of malingering, she being a member of several benevolent societies. Subsequently she was taken really sick, and I found her with marked evidences of phthisis, from which disease she died. At the autopsy, the womb was found completely studded with small tumors, which the microscope showed to be of a fibroid nature and not malignant as was first supposed.

DR. BOISLINIERE:—Fibroids are very common among negroes.

DR. FORD:—That is the opinion of Thomas, of New York, who has had considerable experience in Southern practice. One authority asserts that in women over the age of 50 years, at least 50 per cent. have fibroid tumors of the uterus. In this case there was evidently a general fibroidal degeneration. Most of these growths have been interstitial, but some of them now project externally. Had they been developed earlier, some of them might have been pedunculated, growing from the inner aspect of the uterus.

DR. HUGHES:—If these tumors were developed before the time when the woman first complained of pain, it is not absolutely certain that she was malingering. The pain may have been the result of the existence of these fibroids.

DR. PREWITT:—In connection with this subject there is a point suggested, which came up in a former discussion upon the placenta and tumor presented by Dr. Fischel, (see page 124.) I mean the possibility of pregnancy in cases of uterine fibroids. In this instance of fibroid degeneration, the woman has evidently never born children, as she had what is known as a "virgin os."

DR. NEWMAN:—On the contrary, it is said she had nine children.

DR. PREWITT:—Then, that is an additional point of interest,

since we have no history of this kind where the os is so characteristic and fibroid degeneration so marked.

Discussion of Yellow Fever.

DR. MOORE said:—In reading about yellow fever I have come to certain conclusions concerning the nature and treatment of this disease. The morbid anatomy of yellow fever, consists as far as has been determined, in gastric inflammation, especially of the mucous membrane, which is found softened and broken down, and congestion of the liver and other viscera. The liver, spleen and stomach seem to bear the onus of the disease and associated with this derangement is the high temperature which is a prominent feature of the disease. Then the kidneys are more or less affected, and in the later stages of the disease, many die from suppression of the renal secretion. Based on this morbid anatomy are three points in the way of treatment: 1. One of the most important indications is to control the excessive temperature, and this can best be done by the wet sheet. 2. The inflammation and congestion of the stomach and the liver requires attention. The local application of cold to a part prevents the determination of the blood to that part and drives the blood from it, and I believe the stomach can be protected in yellow fever by the constant application of cold to the epigastrium, and the free use of cold water and crushed ice internally. 3. The suppression of urine must also be guarded against. The indication as far as local treatment goes, is to keep constantly applied to the patient's loins warm fomentations, dry cups, etc. Thus by controlling the animal temperature by the wet sheet, preventing the determination of blood to the chylopoëtic organs by the local application of cold and keeping up the secretions of the kidneys by perpetual warm fomentations, it seems to me that yellow fever ought to be conducted to a favorable result.

DR. JOHNSTON:—The application of cold water in fever has been advocated for the last century, and used in all countries and the patients have died all the same, just as did the recent case of Dr. Chapman, at New Orleans. Those who have actual experience lose their cases, let them adopt whatever treatment they may. We remember that a physician thought he could cure bilious fever by oxygenating the blood and a member of our Society went to Quarantine and treated a case by the inhalation of oxygen, but the patient died. We are also at a loss to know on what it depends. I believe that if any treatment has been at all successful, it is the use of quinine and mercury.

DR. MOORE:—There has been a great deal of discussion regarding the propagation of yellow fever. There is nothing to add to this except that it is produced by some external cause that propagates rapidly and travels slowly. Yellow fever germs are

supposed to travel 40 feet in 24 hours. If you can guard against the disease for a certain length of time you can avert the danger, and by protecting the organs most involved you protect your patient, and this is the object I seek in my treatment.

DR. FORD:—I think that ideas based on the assumption of the inflammatory nature of yellow fever are quite erroneous. There is no sort of proliferative action in typical yellow fever. In those cases which survive for a certain length of time, the various congestions of the organs often pass into inflammation, serving as a foundation for a secondary fever of a typhoid character. Congestion in yellow fever is the essential, the fundamental lesion of the disease. There is congestion of the skin, of the mucous membrane, of the liver, of the spleen, of the kidneys, of the heart, the lungs and the brain. In some cases the congestion of particular organs is more marked than in others, and this may even be characteristic of whole epidemics. We thus have types or modes of disease, recognizing them for instance as head cases, stomach or kidney cases. There are no signs in the ordinary autopsy of yellow fever characteristic of inflammation. The stomach is softened but every indication is that the softening is the result of intense congestion. The gastric wall is abraded, ecchymosed, its integrity destroyed. The capillaries give way so that the blood is effused into the stomach. Fragments of these capillaries are found in the black vomit. The peptic glands cast off their lining cells; this indicates irreparable damage, so very much so that a very acute microscopical observer and practitioner once told me that he never knew a case to recover where he found these peptic cells in the black vomit. In the liver we find general enlargement and an increase in weight of about one-fourth or one-fifth. The heart is found to be softened and with traces of fatty degeneration. The liver is of the well-known *cafe au lait* color. The kidneys are likewise increased in weight. The cuticle substance is increased in thickness, and the whole organ congested. At an early stage of the disease, the urinary tubules are filled with casts, showing that the congestion is so great that it almost amounts to a local stasis. Throughout the body there are unmistakable proofs of an impairment of nutrition due to the defective qualities of the blood and its local stagnation. Nowhere is there any sign of proliferative reaction, until the first or second stage be passed, and then, only where the passive congestion has culminated in stasis. Inflammation, gangrene and the most formidable ulcerations may be thus induced, but are essentially secondary in character.

As regards to the treatment I will merely say, that the use of cold water has been tried from a very early time in the Southern States; cold sponging is very successful. The indication is to reduce the temperature, the great danger of the disease being the excessively high temperature, from 104 to 106 degrees, and even

to 108 during the first few days, the functions being so inordinately stimulated, that the nervous system is very soon completely exhausted, and in the second stage when the fever declines, is unable to support the action of respiration and of the heart.

The matter of cold water was thoroughly tried in 1852 in Charleston. In 1854 I tried it myself. A patient was brought into the hospital with very high fever. I laid him upon the bed upon a blanket which had been soaked in ice water. His temperature was up to 106. I wrapped him up in the blanket, covered him over with another also soaked in ice water, and allowed him to remain there for a couple of hours, when the application was renewed. This was done three times. The febrile movement seemed to be abolished, and the temperature sank during the night to the normal. Next morning he was so well that he went out against my earnest protest. Three or four days afterward he returned with an attack of so grave a form that he died in two days.

A second case was similarly treated two or three days afterwards, in the same hospital. The patient had been sick for three days. There was a marked disposition towards the congestive type. I advised against the cold-packing in this case, but it was instituted, with a fatal result. The blood was doubtless driven violently to the lungs, heart, liver and brain, and he was a dead man before one o'clock that night. I am satisfied that this congestion of yellow fever is due not to the disorganization of the blood corpuscles alone, but to something produced by the action of the economy itself, probably, an abnormal secretion of the biliary salts and biliary coloring matter, which would seem to produce such a grave affection of the blood corpuscles, as to render them unable to convey oxygen to the system in general.

It is thus owing to the intense hepatic action, so characteristic of yellow fever, that the blood is rendered unable to convey oxygen to the various parts of the body. There is a general disposition to congestion in every organ, but, if the lungs are congested, less air is drawn into the system, the blood itself not being able to carry as much oxygen as usual. We have excellent reasons for supposing that the biliary acids, when accumulating in the blood, give rise to grave symptoms, leading to hemorrhages and congestion, and to very great general prostration of the muscular and nervous forces, so that a vicious circle, I would say, begins in the lungs, and in consequence of the decreasing amount of air inspired, the system is gradually less and less supplied with oxygen and a characteristic and progressive hypo-oxygenation of the system is established. In consequence of this failure of tissual nutrition, the blood stagnates in the various organs, in the lungs, in the liver, in the stomach, in the kidneys. From the vascular and tender mucous surfaces of the stomach and intestines blood transudes profusely. These hemorrhages are very considerable

and commence in the stomach. I recollect a case where eight or ten feet at least of coagulated blood was passed by a yellow fever patient, during convalescence, evidently from the small intestines.

The primary indication in the treatment of yellow fever, is of course to reduce the temperature, but no wholly unobjectionable method of doing this has as yet been hit upon. Various methods have been tried with more or less success, but none of those remedial measures assume to deal with the essential cause of the disease. We are unable to reach that as yet. We must I think discover something that will neutralize the action of the septicæmic poison. When we find such a remedy, we will be able to cure yellow fever.

Dr. WYMAN:—I am requested by the Surgeon General to obtain information about cases of yellow fever which have occurred in St. Louis this year, especially as to the result, and as to whether there were any of local origin. Members having had cases this summer will kindly advise me as to the above points.

OCTOBER 19, 1878.

Abdominal Cyst.

DR. G. MOSES:—The specimen which I present is from a female 60 years of age, unmarried, and, except that she was blind, had, until very recently, been in good health. She was a resident of the St. Louis Hospital, where I saw her frequently in the corridors. On the 15th of September she had a chill, and the Sisters had given her a purgative, and when I saw her the next day she had a fever which seemed to be of the ordinary intermittent type. Under the usual treatment, she seemed to entirely recover in a few days. Soon after I found her in a state of collapse. The day before this Dr. Glasgow had seen her, and she then complained of intense pain and tenderness in the right side; it was localized and had come on quite suddenly. She was cold and almost pulseless. Stimulants were given. The next morning her extremities were still cold, her pulse was irregular and feeble, and she was vomiting occasionally. There was a slight increase of dullness on the lower margin of the liver and towards the median line, and there was no tenderness at any point except this. In the next few hours the patient revived, but the pulse continued irregular; a feeble beat and an intermission after every six or eight beats. After a while, general peritonitis was evident, the acute pain diminished and the area

of dullness increased. The epigastrium was dull on percussion at all points, but there was no evidence of fluctuation that could be discovered. Below the umbilicus the abdomen was resonant. The liver dullness extended upward to the right nipple, and was even higher on the left side posteriorly. There was some tendency to diarrhoea. During one day she threw up dark grumous material. She died five weeks after the first attack. On post mortem examination, eighteen hours after death, the body was icteroid; there was but little emaciation and considerable abdominal fat. When what I supposed to be the peritoneum was opened, there was a gush of yellowish fluid, and at least two gallons of this was discharged. The cavity containing this fluid extended high up in the thorax, the accumulation pushing the diaphragm before it; indeed, the diaphragm seemed, in connection with the peritonitum, to form the superior wall of this cavity, which reached above the lower body of the scapula. The left lung was encroached upon, but the heart was not displaced. The liver was also pushed up, was very large, and the left lobe projected into the cavity; there was no opening to the cavity. From the color of the fluid and the odor, I took it to be bile. The spleen was involved in one of the walls of this cavity, and the stomach was also adherent, though outside the walls of the cavity. The walls of this sack were so weak that it was impossible to remove them entire; there was also present all the evidences of peritonitis. The intestines were below the sack, which occupied the entire upper portion of the abdominal cavity and two-thirds of the thorax. I have no distinct theory as to the cause of this condition, and brought it here to get some light upon the subject; but I believe it to have been of old origin. At first I thought that it might have arisen from an obstruction of the common bile duct, but there seems to be no connection between that structure and this cavity.

DR. BERNAYS:—After a short examination, I will venture a diagnosis. It seems to be an abscess which, probably, started in the larger omentum, and extended through into the smaller, and so pressed upwards against the diaphragm, and the boundaries of such an abscess would correspond with what seems to be the boundaries of this.

DR. MOSES:—The fact of the fluid in the cyst having been mixed with bile can be explained when we remember that part of the liver was immersed in the fluid. By a process of endosmosis and exosmosis, there could be an interchange of the fluids in the liver and that within the cyst, and it may be that this was a post mortem change.

DR. MICHEL:—There are also, as I see in this specimen, a large number of gall stones in the gall bladder, and a second st on the posterior wall of the uterus. Now, it may be that a

gall stone became impacted at some time previous to the patient's last sickness; that perforation of the duct took place, and a gall stone dropped down into the peritoneal cavity and set up the inflammation which caused the last-mentioned cyst. It is possible that the opening in the duct remained, and that the bile found its way into the cavity in which the fluid was found. This condition existing for some time would probably cause inflammation of the intestines and peritoneum.

DR. ROBINSON moved that a committee be appointed to examine and report upon this tumor, and the chair selected Drs. Robinson, Moses, Bernays and Michel as the members of said committee.

Horse-Shoe Kidney.

DR. ROBINSON presented a specimen of a so-called horse-shoe kidney, and said the patient had long been subject to gastric disturbance, and finally died from asthma. On making a post mortem examination there was not found any evidence of organic disease; the stomach, however, was much contracted, and would not contain more than half a pint of fluid. Ten days before he examined this patient, who was a physician of this city, and found him complaining of gastric symptoms, pain about the abdomen, and eructation of gas, but there was no evidence of inflammation. He vomited frequently, and was very much emaciated, so that the abdominal organs could be plainly felt. Along the line of the aorta anterior to the lower border of the stomach there was well marked pulsation; a tumor could be felt at this point, and by pressing my hands on each side of it, I thought I felt an aneurism. These symptoms, as can now be seen, were produced by the double kidney which lay across and closely hugged the vessel. This is an interesting condition, as it may be one source of error in the physical diagnosis of aneurism.

DR. ENGELMANN:—I have here another specimen of horse-shoe or lobulated kidney, one lobe being larger than the other. The larger lobe was the right one, and had its blood supply from the right common iliac artery. In the specimen presented by Dr. Robinson there seems to be a connective tissue union of the two kidneys, and the union is doubtless secondary. In this one the condition was evidently of fatal origin.

Cancer of Esophagus.

DR. LUTZ showed an esophageal cancer, and said: I regret that I have but an imperfect history of the man from whom this specimen was taken. He entered the hospital five days before death, and presented a very cachectic appearance. He had aphonia, dysphagia and copious muco-purulent expectoration. The larynx seemed to project, and there were coarse mucus râles. I could not make a laryngoscopic examination, as he was

unable to open his mouth to any extent. At the autopsy I found a cancer of the upper third of the trachea, which perforated the trachea about an inch and a half below the vocal cords.

Reflex Irritation.

OCTOBER 26th, 1878.

DR. BAUDUY showed some gallstones which had been passed by a lady, a patient of another physician, and said he understood she had passed almost a hundred of the same kind within a few days.

He also related the following case: Some five months since, I saw a boy 12 years old, previously well and robust, whom I had known for ten years. He had periodical attacks of great pain in the epigastric region, and this pain now gave evidence of chronicity. I was unable to make a diagnosis. The paroxysms were becoming more frequent, and the boy could not engage in exercise of any kind. I treated him for dyspepsia, and then, remembering the periodicity of the pain, I gave him large doses of quinine, but all to no purpose. The remedies that are most efficacious in the treatment of colic did no good. It certainly was not due to a structural lesion of the stomach, for the pain came on independently of taking food; whereas, we know that in organic gastric disease the pain is increased after meals (Budd). There was no doubt that the pains were real, for the pulse became feeble and rapid, and the surface of the body cold from the agony.

It then occurred to me to examine and see if there was phimosis. I found this condition present to a marked degree, so that it was with difficulty that he could pass his urine. This had probably existed since infancy. At my request, Dr. Lankford circumcised the boy, and found the fore-skin adherent to the glans, and under the prepuce a mass of most offensive smegma. The operation was performed three months since, and from that time the pain in the region of the stomach ceased.

In looking at the literature of the subject, we find it stated on good authority, that paralysis, epilepsy, retention of urine, etc., may result from phimosis. Sometimes balinitis exists from the extending of the inflammation produced by the irritation, and in other cases we find symptoms of stone in the bladder. It is not surprising that phimosis should cause nephrotic disturbance, for we may have a gonorrhœa as the cause of reflex para-

ysis, and we know how intimately the whole nervous system sympathizes with the uterus. In this case there was undoubtedly the relation of cause and effect existing between the irritated glands and the paroxysm of pain.

Dr. Sayre cites two or three cases of paraplegia which he claims was cured by circumcision. A recent writer also attributes enuresis in boys to phimosis, and insists that a cure can always be made by removing the elongated prepuce. I have treated one or two boys for incontinence of urine, for years, unsuccessfully, and am determined to try circumcision.

DR. HUGHES:—The subject of reflex irritation is one of great interest. Sometimes an irritation of one of the ovaries, generally the left one, will start a wave of irritation from which we may have neuralgia, sub-cardial pain and palpitation so common in women. I have under my care now a boy who has epilepsy caused possibly by existing phimosis; and two years ago a case came under my observation in which there was spasmoid contraction of the ham-string muscle. The boy had phimosis, and the necessary operation relieved this, and the muscular retraction soon yielded.

During the war, I saw a man who had continued priapismus for six days, from gonorrhea, and in another case I saw chorea of the dartos muscle from reflex irritation caused by gonorrhea. The fibrillæ of the dartos were in almost continuous action. Cases of reflected uterine irritation are very common, and we all remember that at a recent meeting of the American Medical Association Dr. Sayre presented a child the subject of violent reflex nerve irritation. By merely touching the clitoris in this case the child could be thrown into violent spasms. Removal of the clitoris effected a perfect cure.

DR. JOHNSTON:—Since Baker Browne first advocated clitoridectomy, there have been many to follow his example. I am inclined to think there is too much neurosis and reflex action, and I am opposed to the practice of cutting off the clitoris or remove the prepuce for every pain in the stomach or in case of hysteria. After awhile it will be that every time a man gets drunk it will be due to neurosis, and if these gentlemen keep on we will have to have a sanitarium on every street corner.

DR. FAIRBROTHER:—I would allude briefly to a case very much akin to the one reported by Dr. Banduy. A child 3 years old, the son of a physician on the other side of the river, manifested a series of the most vague and obstinate symptoms. He was rarely free from some exhibition of pain. Even in his sleep, his features were never placid, and he often woke with a shrill cry. Surrounded by tops and all that could be devised in the way of amusement, his features were nearly always overcast with an expression of pain and dissatisfaction. Apparently rug-

ged, with a good appetite, he scarcely ever completed a meal without suddenly jumping down from the table and leaning over a chair or any object within reach. He would utter the most piercing cries of pain. For months the source of this pain was searched for in every organ and part of the anatomy, and he was taken through the entire curriculum of orthodox therapeutics. An elongated prepuce finally being settled upon as the *casus belli*, the operation of circumcision was performed by Dr. Hodgen, and followed by the happiest effects.

Abdominal Cyst (Report of Special Committee).

DR. MOSES, of the committee appointed to report on the case which he had presented at the previous meeting, offered the following notes: There was a large cyst in the abdominal cavity containing about two gallons of fluid having the appearance of bile. Upon close examination it was found that this cyst seemed to have begun at the base, and included the broad ligament of the liver. Its boundaries consisted of the diaphragm, the gastro-hepatic omentum of all the peritoneal surface covering the adjacent organs, the stomach, the liver and the spleen. In addition to this there was some inflammatory exudations which served to strengthen and enlarge the boundaries. It seemed to be a circumscribed peritonitis. The left lobe of the liver projecting into cyst possessed the proper covering but little changed if any. The spleen was contained within the cyst wall and formed a portion of it, and was very much diminished in size. Part of this diminution in size might have been due to the advanced age of the person, 60 years. We know that as age increases after the middle of life, the spleen ordinarily diminishes very much in size; in this case, I suppose the spleen would weigh perhaps two ounces, not more, and was included within the cyst wall and protruded as the left lobe of the liver did into the cavity.

The stomach was adherent to the posterior wall of the cyst and seemed to be perfectly normal, so that we have the boundaries of the cyst consisting of the diaphragm bounding the upper side and upper posterior, lower posterior and anterior portions, and in the lower side the different surfaces of the peritoneum and subjacent organs. The gall bladder was distended perhaps double its usual size, not more, and contained a large number of gall stones. The cystic duct as far as it was preserved in the specimen, seemed to be dilated, but not very much so. Fluid injected into the gall bladder, having reached the opening of the gall duct, would be stopped by one of the contained stones, and then the fluid was retained. The greatest change visible, however, was in the hepatic ducts, which were very much enlarged, so that with ease the finger or even thumb could be passed into them. The left lobe seemed entirely made up of dilated ducts,

the proper tissue of the organ having become almost obliterated. One of these dilated ducts, as shown by the injection (which was made very carefully and with little force), opened by what appeared to be a recent opening a little larger than an ordinary pocket-case director upon the margin of the left lobe, within the cyst, giving thus a ready means of discharging the secretion of the liver into the cyst cavity. The right lobe of the liver seemed to be less charged, somewhat softened, perhaps, a few of the ducts somewhat enlarged, but there was not any very marked change in this portion of the organ; the principal change seemed to be in the left lobe.

The Society will recollect that three weeks before her death, and at the time that the area of dullness rapidly increased, the patient had what appeared to be a condition of collapse. I had already feared that there was suppurative inflammation going on within the liver, and my first impression was that there had been a rupture of an abscess. Peritonitis ensued, but she recovered from this collapse, and for the three weeks that she lived afterwards, the area of dullness constantly increased. I think it, in fact, very probable that it was at that time that this biliary duct opened and discharged itself into the cyst cavity; the rupture seemed to be very recent. The contents of the cyst had the appearance of an ordinary secretion of the liver, mixed with some inflammatory products to a limited extent. Dr. Michel examined this fluid under the microscope, and confirms this statement.

In examining more into the history of this case, I find that the patient had been in the Hospital thirty-one years, and previous to this attack had had no sickness of any kind.

Dr. PREWITT:—This case recalls one which I saw some years ago, when I had charge of the City Hospital. A man 35 years years old had aches, and was much distended. At one time I drew off from him two buckets of fluid of a reddish color. After a while he died, and the assistants made a post mortem examination. They sent me word that the man had no intestines. On first sight this seemed to be the case; there was a large cavity in the abdomen enclosed in a capsule of brownish appearance. When, after my arrival, this was dissected, we found the viscera beneath, and for the most part pushed up into the left hypocondrium, and very much reduced in size. The cyst was the result of chronic peritonitis.

Dr. MURD:—The boundaries of the sac have been very well described by Dr. Moses. It was situated in front of the gastro-hepatice and gastro-splenic omentum, and the stomach being pushed downward and forming a part of the inferior boundary, while the omental adhesion to the anterior abdominal wall limited its extension downwards. The abdominal walls and diaphragm formed its anterior superior wall. In connection with

the conditions of the liver and gall bladder, these anatomical relations throw some light on the origin of this collection of fluid. The gall bladder is full of gall stones, and the hepatic ducts are largely dilated throughout the liver, so much so as to indicate long-continued obstruction to the escape of the bile. The valvular opening of the cystic duct here prevented any very great distension of the gall bladder, from the distending force of the fluid in the common bile duct. The liver substance is much atrophied, and seems to be composed almost entirely of hepatic ducts. It is probable that there has been long-continued obstruction in the ductus communis choleductus which, at some time, has ulcerated, producing adhesive circumscribed peritoneal inflammation with the beginning of this abscess sac. It seems to me that the greater part of the cyst must have been of long standing, and that the rapid increase during the last few weeks of life may have been due to the escape of fluid through the ruptured hepatic duct which we found in the left border of the liver, and to the inflammation produced by it. The greatest part of the contents being, of course, the results of inflammation, a serous exudation.

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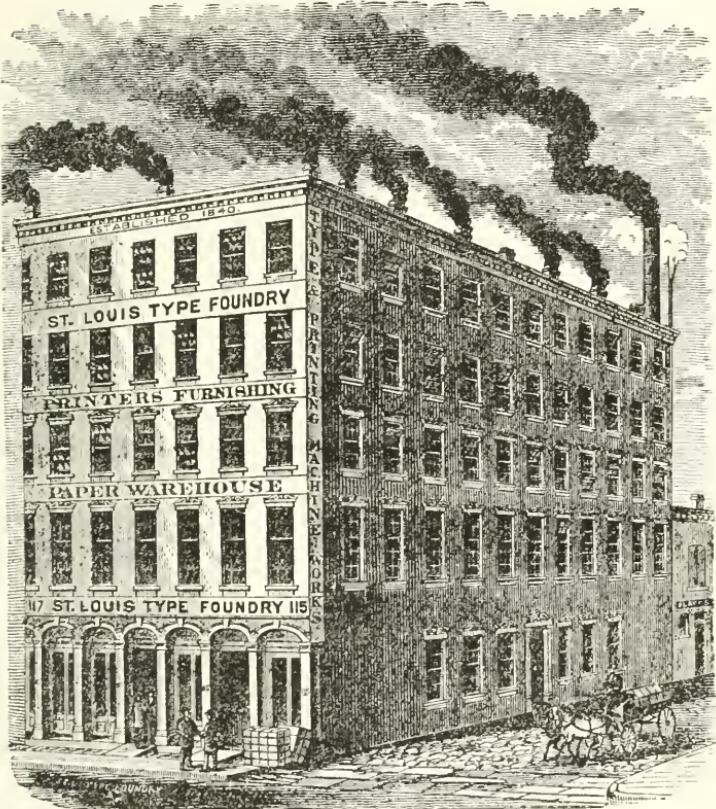
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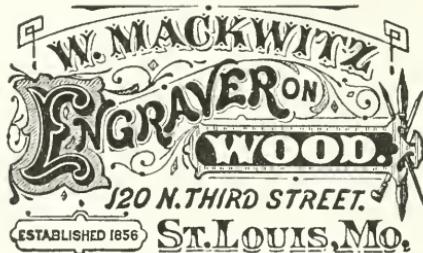
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